

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

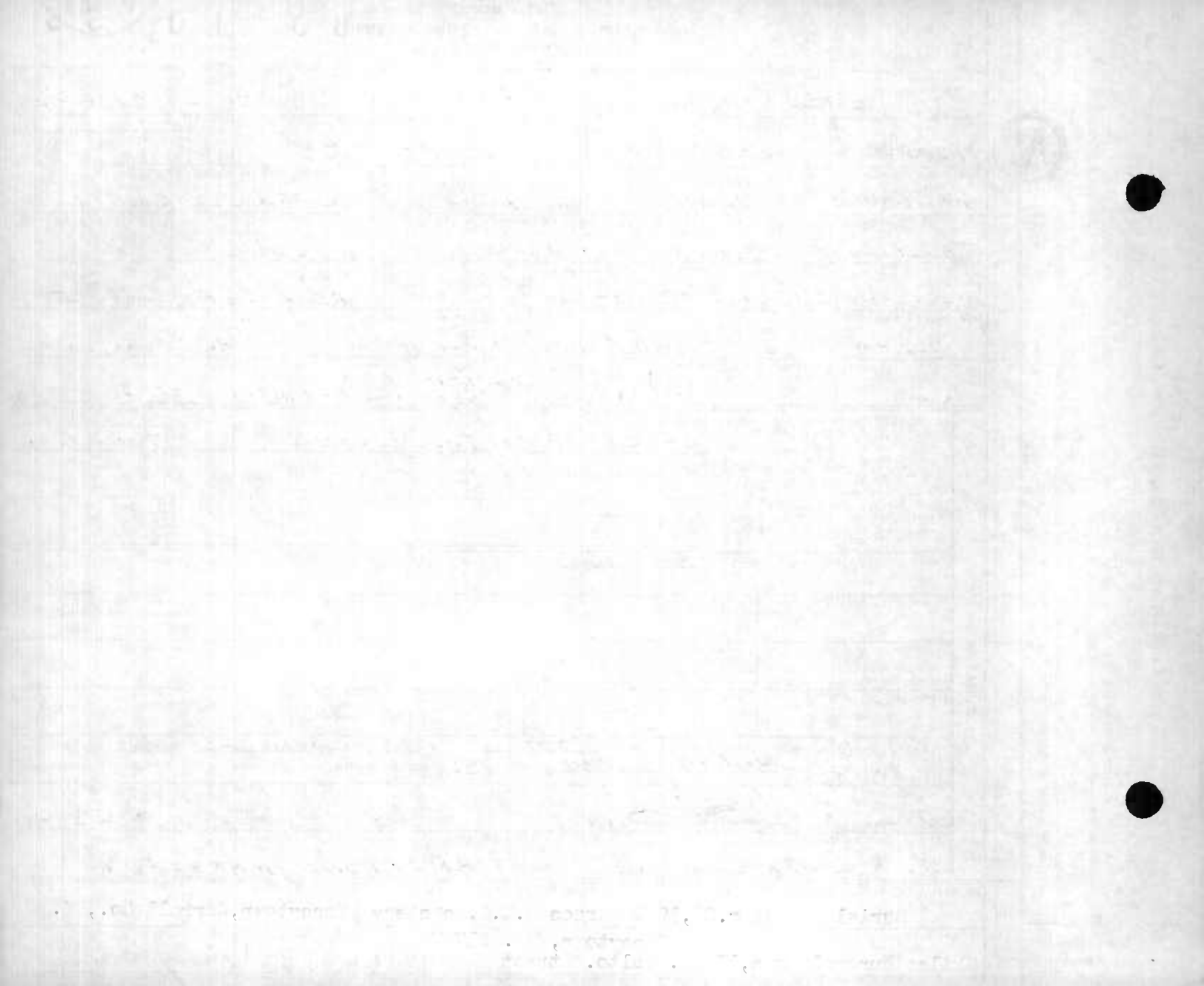
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 0 2 5 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) ETHEL ROMAINE AIRING				2a. DATE OF DEATH MONTH DAY YEAR 4 23 80		2b. HOUR MIN. 6 45 A M	
3 SEX FEMALE		4 RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 3 25 95		6 AGE (IN YEARS LAST BIRTHDAY) 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY, MD	
10. CITY OR TOWN OF DEATH TANEYTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3384 F.S. KEY HIGHWAY		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN TANEYTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM E. DAVIDSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIRGINIA HELTEBRIDLE		13e. STREET ADDRESS REAR 23 A GEORGE ST.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-14-1714		17. INFORMANT KENETH AIRING ADDRESS 3384 F.S. KEY HIGHWAY, TANEYTOWN, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE COLON 1539							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ZONE YEAR
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONTRIBUTING TO DEATH							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="radio"/> (this hospital) attended the deceased from OCT. 19 79 to APRIL 23 19 80 , that <input type="radio"/> (we) last saw the deceased alive on 4-16-80 19 80 , and that in my <input checked="" type="radio"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="radio"/> (we) did (did not) view the body after death.							
22b. SIGNATURE Wm. R. Linthicum, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-23-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm. R. LINTHICUM, M.D.		22e. ADDRESS TANEYTOWN, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 26, 1980		23c. NAME OF CEMETERY OR CREMATORY Grace U.C.C. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Taneytown, Carroll Co., Md.	
24. FUNERAL DIRECTOR NAME Taneytown, Md. 21787				25a. DATE REC'D. BY REGISTRAR APR 24 1980		25b. REGISTRAR'S SIGNATURE Hickey McCreedy	
Skiles Funeral Home, 136 E. Balto. Street							

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 0 2 5 6	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) EMMA L. AKEHURST						2a. DATE OF DEATH MONTH DAY YEAR APRIL 2, 1980		2b. HOUR 7:27 P.M.			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 09 29 88		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD.					
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WESTMINSTER NURSING + CONVALESCENT CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Woodbine		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RD			
14. FATHER'S NAME FIRST MIDDLE LAST John H. Hare				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Bloom							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-14-8494A		17. INFORMANT ADDRESS Sykesville, Md. David A. Akehurst, 6762 Marvin Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs Years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 2		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) (this hospital) attended the deceased from 3-28 , 19 80 , to 4 , 19 80 , that (b) (we) lost saw the deceased die on 3-28 , 19 80 , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above (d) (we) did not view the body after death.											
22b. SIGNATURE Alva S. Baker M.D.				DEGREE M.D.				22c. DATE SIGNED 4-2-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alva S. Baker M.D.				22e. ADDRESS 218 Wash Hgts Med Center Westminster MD 21157							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-4-1980		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.					
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.				25a. DATE REC'D. BY REGISTRAR APR 7 1980		25b. REGISTRAR'S SIGNATURE Pietro Mc...					

Woodville

Woodville

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Woodville

Charles H. Hester, Jr., Woodville, Mo.

1922

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DHMH - 16 50M 7/77
(VRA 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 0 2 5 7
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
CATHERINE Sykes ALBRECHT		Female		W	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	
MONTH DAY YEAR 03 27 11		69 YRS.		Balt City Md.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Carroll		Carroll		Westminster	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Westminster Nursing Center Washington Rd.		School Teacher			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN	
md		Carroll		Westminster	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
John Milton Sykes		Catherine C Ebert Sykes		949 Washington Rd.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		215-10-4235		Albert G. (Chief) Albrecht West. Md. 21157	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		19. DATE OF OPERATION		20a. AUTOPSY?	
1749 Carcinoma of breast		11-12-79		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DUE TO, OR AS A CONSEQUENCE OF		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(b)		YES <input type="checkbox"/> NO <input type="checkbox"/>		~ 7 yr	
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
CVA 10-79					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 11-28, 19 79, to 4-11, 19 80, that (2) (we) last saw the deceased alive on 4-10, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.		22b. SIGNATURE Alva S. Baker M.D.		22c. DATE SIGNED 4-11-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE	
Alva S. Baker M.D.		218 Washington Heights Medical Center Westminster MD 21157		APR 16 1980	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		4/14/80		Westminster Cemetery	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. CITY OR TOWN	
Thomas D. Fletcher & Son Funeral Home 254 East Main St. Westminster, Md. 21157				Westminster Carroll Md.	

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 0 2 5 8	
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR			
Samuel Guy Arnold Jr.								4 29 1980 1045 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		Oct. 17 1895		85					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Westminster		U.S.A.				Carroll MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		1203 Deer Park Rd. Westminster Md.				Retired		Carpenter			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Maryland				Carroll		Westminster		13e. STREET ADDRESS Westminister, Md. 1203 Deer Park Rd. 21157			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Samuel Guy Arnold Sr.				Caroline Saylor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Westminister, Md.					
No				216-01-6114		Hilda Arnold 1203 Deer Park Rd. 21157					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>of a D</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>hemiplegia involving catheter 10 yrs</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <i>not out of bed for 10 yrs</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
				P.M. <i>none</i> 19 <i>68</i>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased <i>4-6-80</i> 19 <i>68</i> to <i>4-29-80</i> 19 <i>80</i> , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>James G. Saffell</i>				22c. DATE SIGNED <i>4-30-80</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>James G. Saffell</i>				22e. ADDRESS <i>64 N PIN ST Westminster Md 21157</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				May 2, 1980		Trinity Lutheran Cemetery		Westminister Carroll Md.			
24. FUNERAL DIRECTOR NAME <i>James D. Fletcher & Son Funeral Home</i>				25. DATE REC'D. BY REGISTRAR <i>MAY 5 1980</i>				25b. REGISTRAR'S SIGNATURE <i>Pitney K. Bundy</i>			
24b. ADDRESS <i>Westminister, Md. 21157</i>											

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 1 0 2 5 9
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) DURALL C. BROWN		2a. DATE OF DEATH MONTH DAY YEAR 4/25/80 April 25 1980	
3. SEX MALE		4. RACE WHITE	
5. DATE OF BIRTH MONTH DAY YEAR SEPT 19 1901		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL G. GENERAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Admin.		12b. KIND OF BUSINESS OR INDUSTRY CREAMERY	
13a. STATE MD		13b. COUNTY CARROLL	
13c. CITY OR TOWN Finksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 2815 Armagost			
14. FATHER'S NAME FIRST MIDDLE LAST John Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alverta Durall	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-03-5621	
17. INFORMANT ADDRESS Saura Brown Finksburg, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) arteriosclerotic heart disease (c) arteriosclerotic heart disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/21 , 19 80 , to 4/25 , 19 80 , that (I) (we) last saw the deceased alive on 4/24 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Sandra Spence Schade MD		22c. DATE SIGNED 4/25/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-28-80	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balt. MD	
24. FUNERAL DIRECTOR Robert E. Prill		25a. DATE REC'D. BY REGISTRAR MAY 1 1980	
25b. REGISTRAR'S SIGNATURE Robert E. Prill			

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

1/25/20 (1/25/20)

Carroll C. Brown

Male White 247 19 1901

112A Carroll

Western Carroll C. General Name

Carroll Finishing 2016 1901

John Brown

216-0-221 216-0-221 216-0-221

216-0-221 216-0-221 216-0-221

1/25/20

X

1/25/20

X

216-0-221 216-0-221 216-0-221



FOR
STATE
REGISTRAR

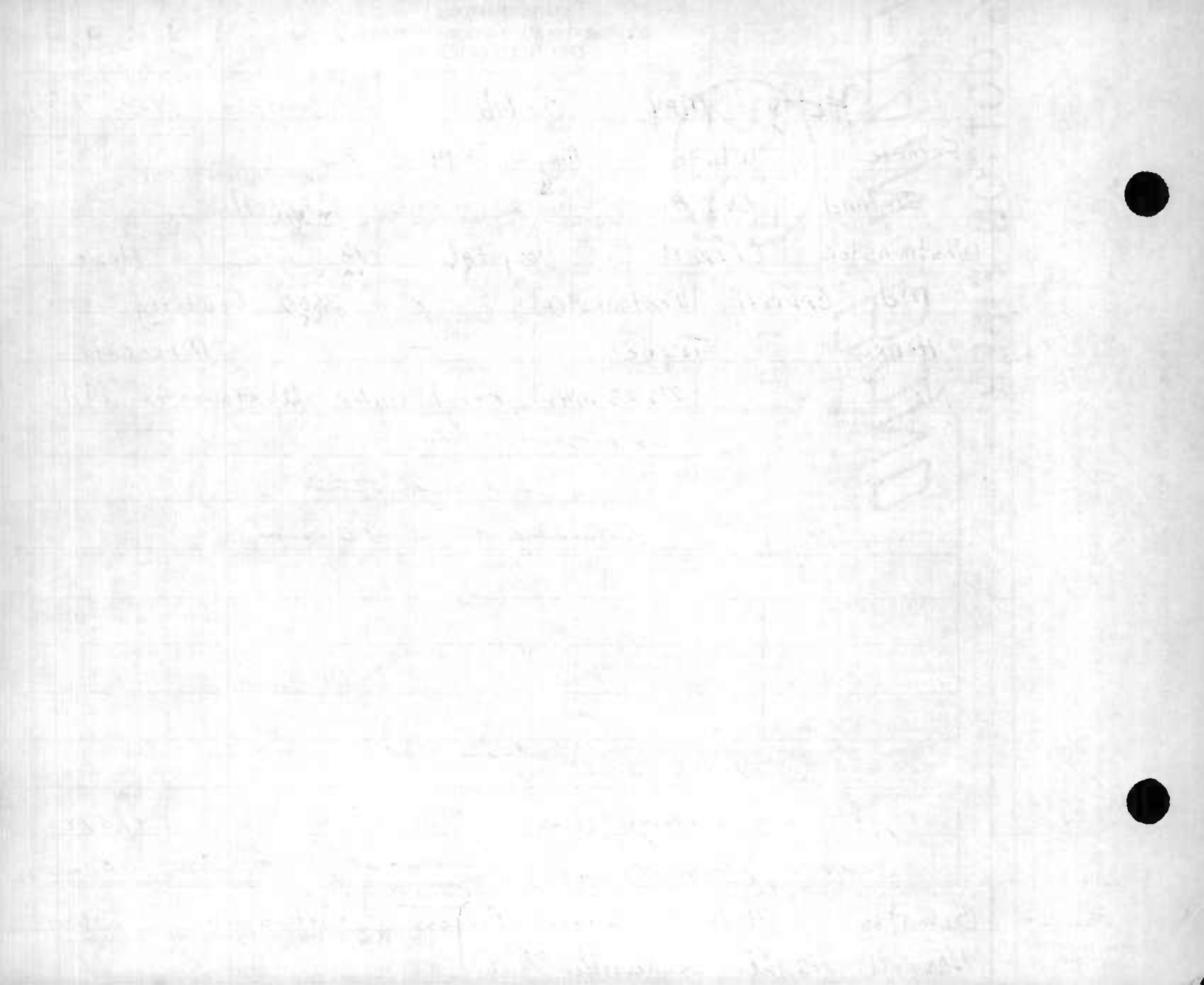
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
OFFETTY MAY Cobb		April 15, 1980		2357	
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)		
Female	White	May 2, 1894	85		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
England	U.S.A.		CARROLL MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Westminster	Carroll Co. Hospital	Housewife		Home	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.		CARROLL	Westminster	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	3607 Dewberry Circle
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME			
Henry TOYNE		MARSHALL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17 INFORMANT ADDRESS		
No		21628 1446	Beryl Wiles Westminster, Md.		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> 410 - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Heart Disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>April 15</u> , 19 <u>80</u> , to <u>April 15</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>April 15</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>John S. Harshey, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 4/15/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
JOHN S. HARSHEY M.D.		8 Anchor St. Westminster, Md. 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation	4-16-80	Security Processors		Catonsville, Md.	
24 FUNERAL DIRECTOR NAME		ADDRESS			
Harry W. Haight		Lykeville, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					8 0 1 0 2 6 1					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
FIRST MIDDLE LAST Ellsmore Reed Cooper					MONTH DAY YEAR 4 14 80					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 21, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7b. HOUR 2 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Road Worker		12b. KIND OF BUSINESS OR INDUSTRY Balto Co. Highway		
13a. STATE 13b. CITY OR TOWN 13c. STREET ADDRESS Maryland Baltimore Owings Mills 123 South Ritters Lane										
14. FATHER'S NAME FIRST MIDDLE LAST Ernest Cooper					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Kellog					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 215-03-0480		17. INFORMANT 2 Selter Ct. Reisterstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>arteriosclerotic heart disease</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>4/12</u> 19 <u>80</u> to <u>4/14</u> 19 <u>80</u> , that (I) (we) lost <u>4/13</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>P.W. Espenschied</u>						22c. DATE SIGNED 4/14/80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) P.W. Espenschied		
22e. ADDRESS Westminster, Md.						22f. ADDRESS Owings Mills, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 16, 1980			23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg, Carroll, Md.	
24. FUNERAL DIRECTOR NAME <u>H. J. Eichland</u>						25a. DATE REC'D. BY REGISTRAR APR 17 1980		25b. REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>		

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Carroll M. Cowan			2a. DATE OF DEATH MONTH 4 DAY 1 YEAR 80			2b. HOUR 4:30 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Jan. DAY 30 YEAR 1928		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Reisterstown		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen. Hospt.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Heavy Machine Operator		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Baltimore 13c. CITY OR TOWN Owings Mills			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 135 Maybin Court				
14. FATHER'S NAME FIRST Charles L. MIDDLE Cowan LAST 				15. MOTHER'S MAIDEN NAME FIRST Lillian V. MIDDLE Sullivan LAST 					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. 212-22-6567		17. INFORMANT ADDRESS Jean B. Cowan, Owings Mills, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4476 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure (c) Mineralized Vegetative Aortitis DUE TO, OR AS A CONSEQUENCE OF - DUE TO, OR AS A CONSEQUENCE OF - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH WKS YRS								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
21g. I certify that I (this hospital) attended the deceased from 1 April 1980 to 1 April 1980 , that I (we) last saw the deceased alive on 1 April 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not see the body after death)									
21h. SIGNATURE Richard A. Jones				DEGREE		21i. DATE SIGNED 3 April 80			
21j. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Richard A. Jones				22e. ADDRESS Westminster, Md. 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 4, 1980		23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial		23d. LOCATION CITY OR TOWN Sykesville, Md. COUNTY STATE 			
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Reisterstown, Md. 21136 ADDRESS 				25. DATE REC'D. BY REGISTRAR APR 7 1980		25b. REGISTRAR'S SIGNATURE Anthony McCreary			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "RECEIVED" and "OFFICE" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

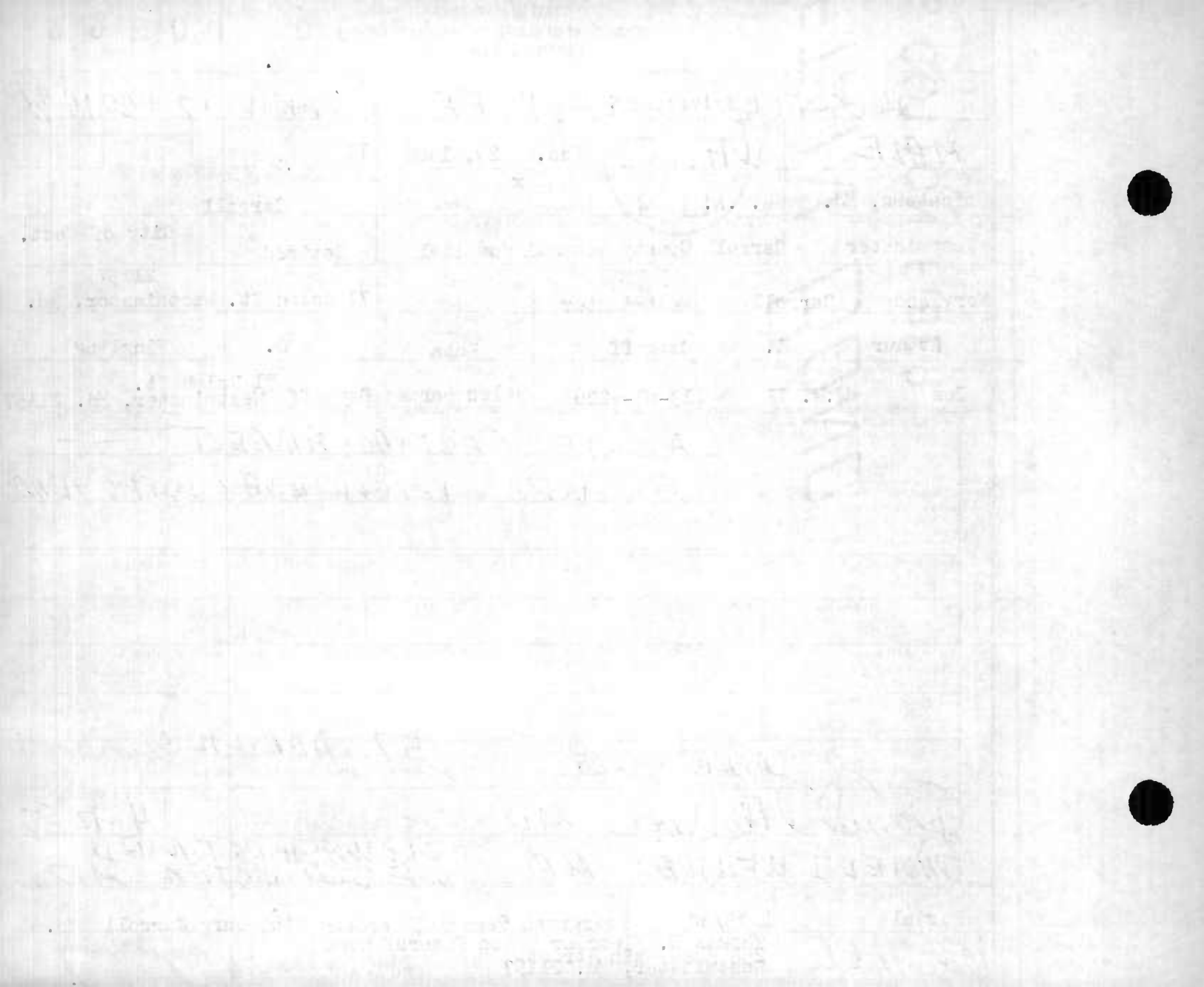
BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RUSSELL Sylvester DAYHOFF			2a. DATE OF DEATH MONTH DAY YEAR APRIL 17 1980		2b. HOUR 14 47
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Dec. 29, 1908		6 AGE (IN YEARS LAST BIRTHDAY) 71	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 14 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Uniontown, Md.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10 CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY City of West.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Carroll	13c CITY OR TOWN Westminster	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST Arthur S. Dayhoff			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna O. Yingling		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b SOCIAL SECURITY NO. 413-01-9226		17 INFORMANT ADDRESS Helen Barnes Dayhoff 71 Ralph St. Westminster, Md. 21157
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC ARREST 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASC. V.D. - PERIPHERAL VASC. DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from OCT 57 to APRIL 12 80 and that (I) (we) lost saw the deceased alive on APRIL 12 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death.					
22b. SIGNATURE Daniel I. Welliver		DEGREE MD		22c. DATE SIGNED 4-12-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER		22e. ADDRESS 218 WASHINGTON RD WESTMINSTER MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/15/80	23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens Finksburg		23d. LOCATION CITY OR TOWN COUNTY STATE Carroll Md.
24. FUNERAL DIRECTOR Dele Fletcher		25. East Main Street Westminster, Md. 21157		26. REGISTRAR APR 17 1980	



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

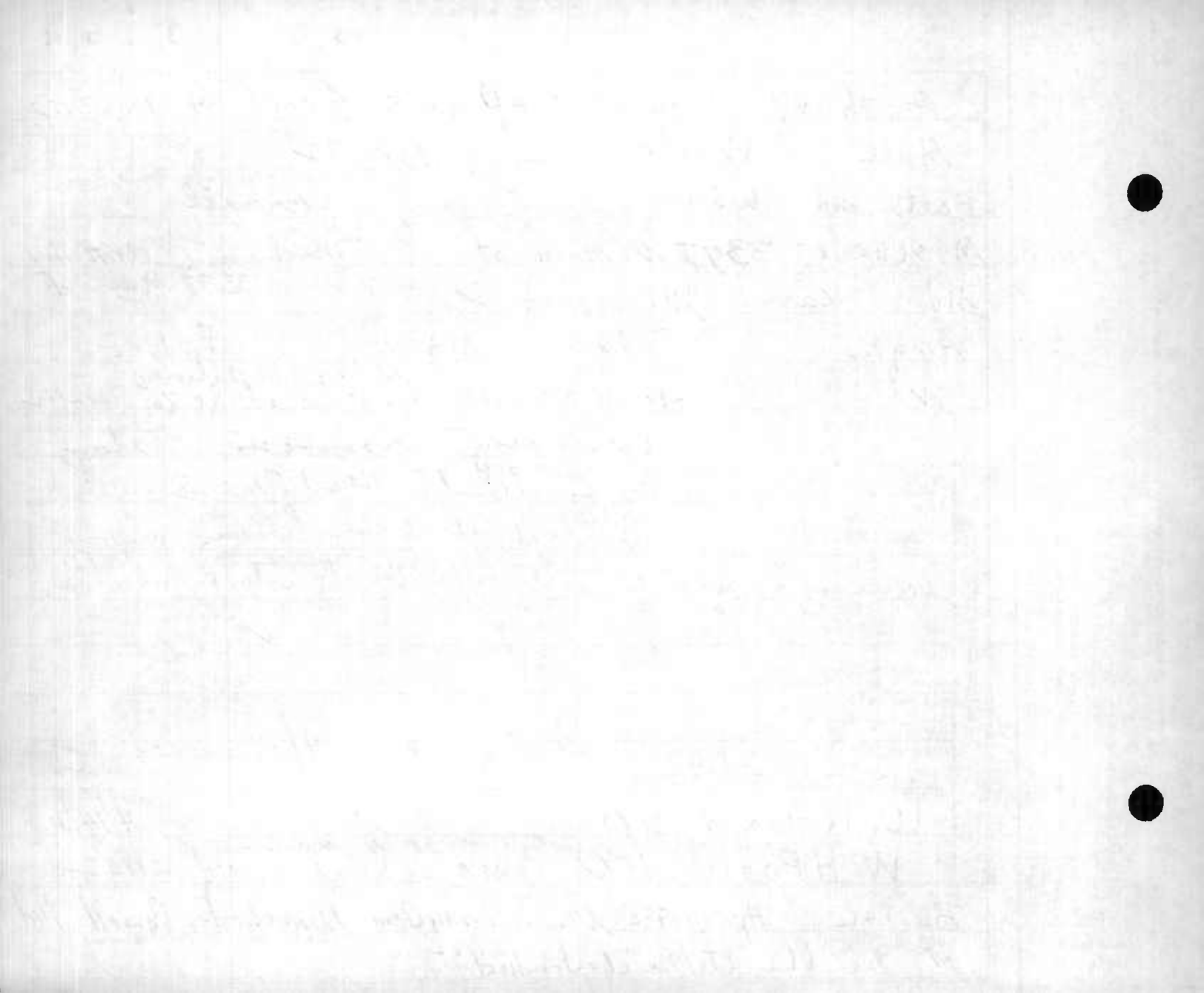
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anthony Michael DePalmer			2a. DATE OF DEATH MONTH DAY YEAR April 14-1980		2b. HOUR 3:55 PM
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR Jun 10 1908		6 AGE (IN YEARS LAST BIRTHDAY) 72	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md		7b. CITIZEN OF WHAT COUNTRY? USA.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. BALTIMORE CITY OR COUNTY OF DEATH Carroll			9b. BALTIMORE CITY OR COUNTY OF DEATH Carroll		
10 CITY OR TOWN OF DEATH Manchester		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3377 N. MAIN ST.		12a. USUAL OCCUPATION (NATURE OF WORK FOR MOST OF WORKING LIFE) Mechanics	
12b. KIND OF BUSINESS OR INDUSTRY Clothing		13a. STREET ADDRESS 3377 Main St			
14 FATHER'S NAME FIRST MIDDLE LAST Angelo DePalmer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Felice			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216 050 645		17. INFORMANT MARY DePalmer	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 410 - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pneumonia Coronary prostatic & Chronic obstructive pulmonary					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 3/14 19 80 to 4/14 19 80 , that (I) (we) last saw the deceased alive on 3/14 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W. H. Foard MD		DEGREE MD		22c. DATE SIGNED 4/14/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. H. Foard MD		22e. ADDRESS 25 N. Main St Manchester, Md 21102			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE Apr. 17, 1980		23c. NAME OF CEMETERY OR CREMATORY New Lutheran Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Manchester Carroll Md		23e. DATE REC'D BY REGISTRAR 2102			
24 FUNERAL DIRECTOR NAME ADDRESS J. E. Schmitt Manchester, Md.					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

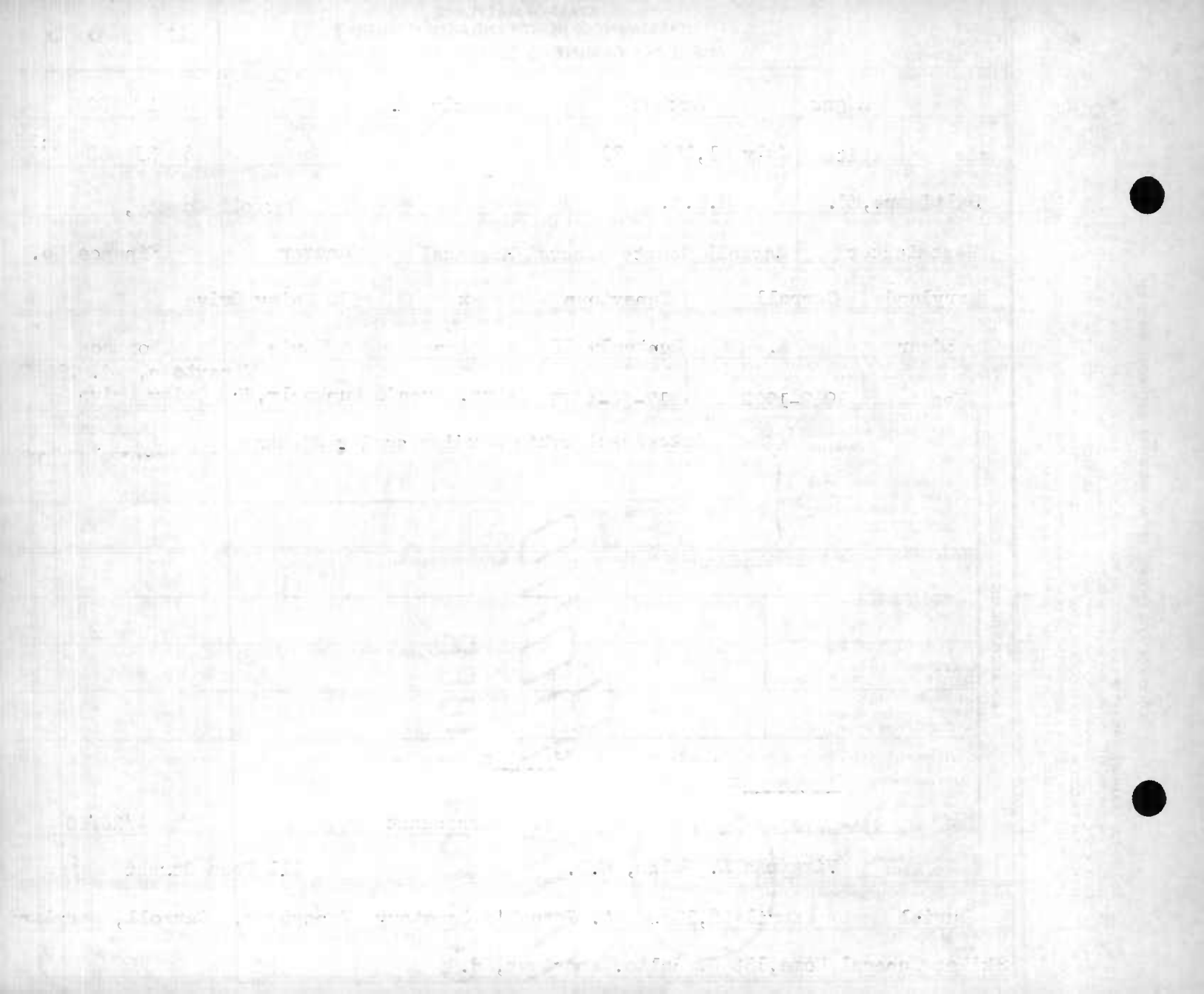
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DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Edgar Arthur Dunkerly III		4 25 1980		8:35 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	7. IF UNDER 24 HRS.
Male	White	July 21, 1948	31 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Baltimore, Md.	U.S.A.		Carroll County, MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Westminster	Carroll County General Hospital	Manager	Finance Co.		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Carroll	Taneytown	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	530 Daisy Drive	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Edgar A. Dunkerly II		Anna Marie Thompson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes 1969-1972		217-50-4579		Taneytown, Md. 21787 Mrs. Brenda Dunkerly, 530 Daisy Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1 DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Virginia L. Dolan		Assistant		4/26/80	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Virginia L. Dolan, M.D.		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	April 28, 1980	St. Joseph's Cemetery		Taneytown, Carroll, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Skiles Funeral Home, 136 E. Balto. Taneytown, Md.		APR 30 1980		History McCready	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					8 0 1 0 2 6 6					
CERTIFICATE OF DEATH					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY E. FLATER					2a. DATE OF DEATH MONTH DAY YEAR 04-19-80			2b. HOUR 0430^A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 04 26 05		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS 11 13		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hanover, Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD.				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Redding					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Green					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-10-0507E		17. INFORMANT ADDRESS John L. Flater, Sr., Same As #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4140 DUE TO, OR AS A CONSEQUENCE OF (b) cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 days 16 days										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Systemic Hypertension										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Contracheo N. Aganna					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/19/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHEO N AGANNA					22e. ADDRESS 174 E. Main St - Westminster, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-21-1980		23c. NAME OF CEMETERY OR CREMATORY Providence		23d. LOCATION CITY OR TOWN COUNTY STATE Gamber, Carroll, Md.				
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr.,					ADDRESS Skylesville, Md.		25a. DATE REC'D. BY REGISTRAR APR 28 1980		25b. REGISTRAR'S SIGNATURE Helen McCready	

BP _____

TO : DIRECTOR, FBI (100-371100)
FROM : SAC, NEW YORK (100-100000) (P)
SUBJECT: [Illegible]
RE: [Illegible]

[Illegible handwritten text]

Very truly yours,
[Illegible signature]
Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

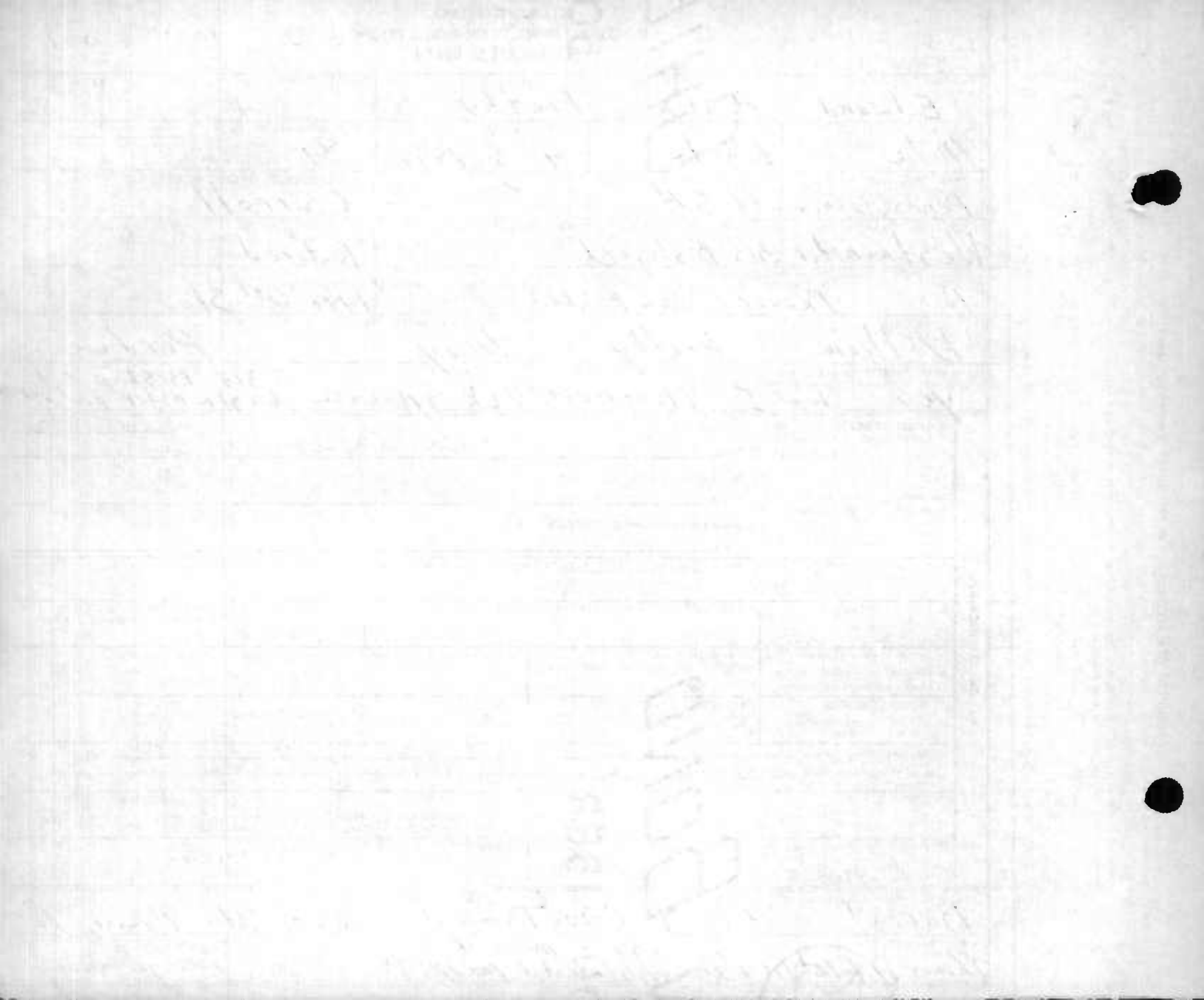
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

8 0 1 0 2 6 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edward Austin Frethy			2a. DATE OF DEATH MONTH DAY YEAR 4 21 80			2b. HOUR 10:20 PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4-3-1899		6. AGE (IN YEARS LAST BIRTHDAY) 81		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 315 Bishop Ct.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Pa.					13b. COUNTY Beaver		13c. CITY OR TOWN New Brighton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Frethy					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Pardue					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WW I 170-01-0148		17. INFORMANT ADDRESS Vick Syracuse 315 Bishop Ct. Westminster Md 21157					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ca To Lung, Bone & Brain 1552 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Liver Ca (c) Brain									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Ascho, Diabetes										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from August 19 79 to 4-21 80 , that (I) (we) lost saw the deceased alive on 4-19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Manuel J. Sevilla					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4-22-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Manuel J. Sevilla					22e. ADDRESS 419 C Malcolm Dr Westminster					
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial			23b. DATE 4-25-80		23c. NAME OF CEMETERY OR CREMATORY Grove Memorial			23d. LOCATION CITY OR TOWN COUNTY STATE New Brighton Beaver, Pa.		
24. FUNERAL DIRECTOR NAME Thomas D. Fletcher & Son					25a. DATE REC'D. BY REGISTRAR 254 E. main St. Westminster Md 21157			25b. REGISTRAR'S SIGNATURE Histery McQuay		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 0 2 6 8	
1 - FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) ANNA A. GLASCO						2a. DATE OF DEATH MONTH DAY YEAR APRIL 23 1980		2b. HOUR 01:23 M			
3. SEX F.M.		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 24. 1895		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MARYLAND MD.					
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL COUNTY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. REGISTERED NURSE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY CARROLL CO. 13c. CITY OR TOWN ELDERSBURG						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 407 RONSDALE RD. ELDERSBURG			
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN HOLLAND				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE SHERMAN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT ADDRESS WILLIAM W. GLASCO 407 RONSDALE RD. ELDERSBURG MD. 21784							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Malignant Melanoma with diffuse Metastases APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4-23-1980, to 4-23-1980, that (I) (we) lost saw the deceased alive on 4-23-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Chitrachedu Naganne				DEGREE MD		22c. DATE SIGNED 4-23-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHEDU NAGANNA				22e. ADDRESS 174 E. MAIN ST. WESTMINSTER MD 21157							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 4/24/80		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE CATONSVILLE, BALTO. CO. MD.					
24. FUNERAL DIRECTOR LONG BYERS FUNERAL DIRECTORS, P.A. 8728 LIBERTY RD. RANDALLSTOWN, MD. 21133						25a. DATE REC'D. BY REGISTRAR APR 25 1980		25b. REGISTRAR'S SIGNATURE H. J. McCreedy			

BP



RECEIVED
JAN 11 1891
NEW YORK

TO THE
HONORABLE
MEMBERS OF THE
LEGISLATIVE
COMMISSION

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JAN 11 1891
NEW YORK

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JAN 11 1891
NEW YORK

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JAN 11 1891
NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <u>HELEN Bowers Graft</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>April 5, 1980</u>			2b. HOUR <u>0840</u>			
3. SEX <u>female</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>3 18 07</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>73</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Carroll</u> MD.					
10. CITY OR TOWN OF DEATH <u>Westminster</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Carroll Co. Gen Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Bookkeeper</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>store</u>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE <u>Md</u>			13b. COUNTY <u>Carroll</u>		13c. CITY OR TOWN <u>Westminster</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Arthur C Bowers</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Elsie Mathais</u>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>			16b. SOCIAL SECURITY NO. <u>n/a</u>		17. INFORMANT <u>Betty Click</u>		ADDRESS <u>Pa. Ave, Westminster</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular insufficiency</u> <u>4370</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral atherosclerosis</u> (c) <u>ASHD</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>March 19, 1980</u> to <u>April 5, 1980</u> , that (he) (we) last saw the deceased alive on <u>April 5, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>John S. Marshey, MD</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4/5/80</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN S. MARSHEY, MD</u>				22e. ADDRESS <u>8 Madison St. Westminster Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>4-7-80</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Kriders</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Westminster CARROLL MD</u>					
24. FUNERAL DIRECTOR <u>Robert Kyle Smith Jr. Westminster, Md.</u>						25a. DATE REC'D. BY REGISTRAR <u>APR 10 1980</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP

UNITED STATES
DEPARTMENT OF JUSTICE
CRIMINAL DIVISION

TO: SAC, NEW YORK
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]

DATE: 11-10-58
BY: [Illegible]

[Illegible text block containing multiple lines of text, possibly a memorandum or report body]

RECEIVED
NOV 11 1958
FBI NEW YORK

sent 5 copies
1/12/80 RA 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET Rose Henze						2a. DATE OF DEATH MONTH DAY YEAR April 24, 1980		2b. HOUR 1230^P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 16, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Md.		13b. COUNTY CARROLL		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7546 Norwood Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Albert Walsh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214 82 1851		17. INFORMANT ADDRESS George Henze Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 436- DUE TO, OR AS A CONSEQUENCE OF: (b) Albers-Schönberg's Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF: (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) systemic hypertension and diabetes mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4-18- 19 80 , to 4-24- 19 80 , that (I) (we) last saw the deceased alive on 4-24- 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Chitra Chedra Naganne				DEGREE MD				22c. DATE SIGNED 4-24-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRA CHEDRA NAGANNE MD				22e. ADDRESS 174 E. Main St Westminster 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-28-80		23c. NAME OF CEMETERY OR CREMATORY Lake View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md.			
24. FUNERAL DIRECTOR NAME Harry W. Haight				ADDRESS Sykesville, Md.		25a. DATE REC'D BY REGISTRAR MAY 1 1980		25b. REGISTRAR'S SIGNATURE Robert J. Brady	

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Lucy Marie Hess		4 1 80		2145	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	Feb 12 1899	81	MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Carroll County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Westminster	Carroll County General Hospital		Housewife		Own Home
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Carroll	Taneytown	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	5718 Taneytown Pike	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
John H. Hilterbrick		Lucy Keith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT	
No		212-62-3572		Wilbert N. Hess 5718 Taneytown Pike	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>renal failure</u> 4039 DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/16</u> 19 <u>80</u> to <u>4/1</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4/1</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Park W. Espenschade, Jr.</u> DEGREE M.D.		22c. DATE SIGNED <u>4/1/80</u>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. ADDRESS			
Park W. Espenschade, Jr., M.D.		Westminster, Md. 21157 218 Washington Hgts Medical Center			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Apr. 4, 1980		Lutheran Cemetery	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME Skiles Funeral Home, 136 E. Balto. St.		ADDRESS Taneytown, Md. 21787		APR 7 1980 <u>Park W. Espenschade, Jr.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

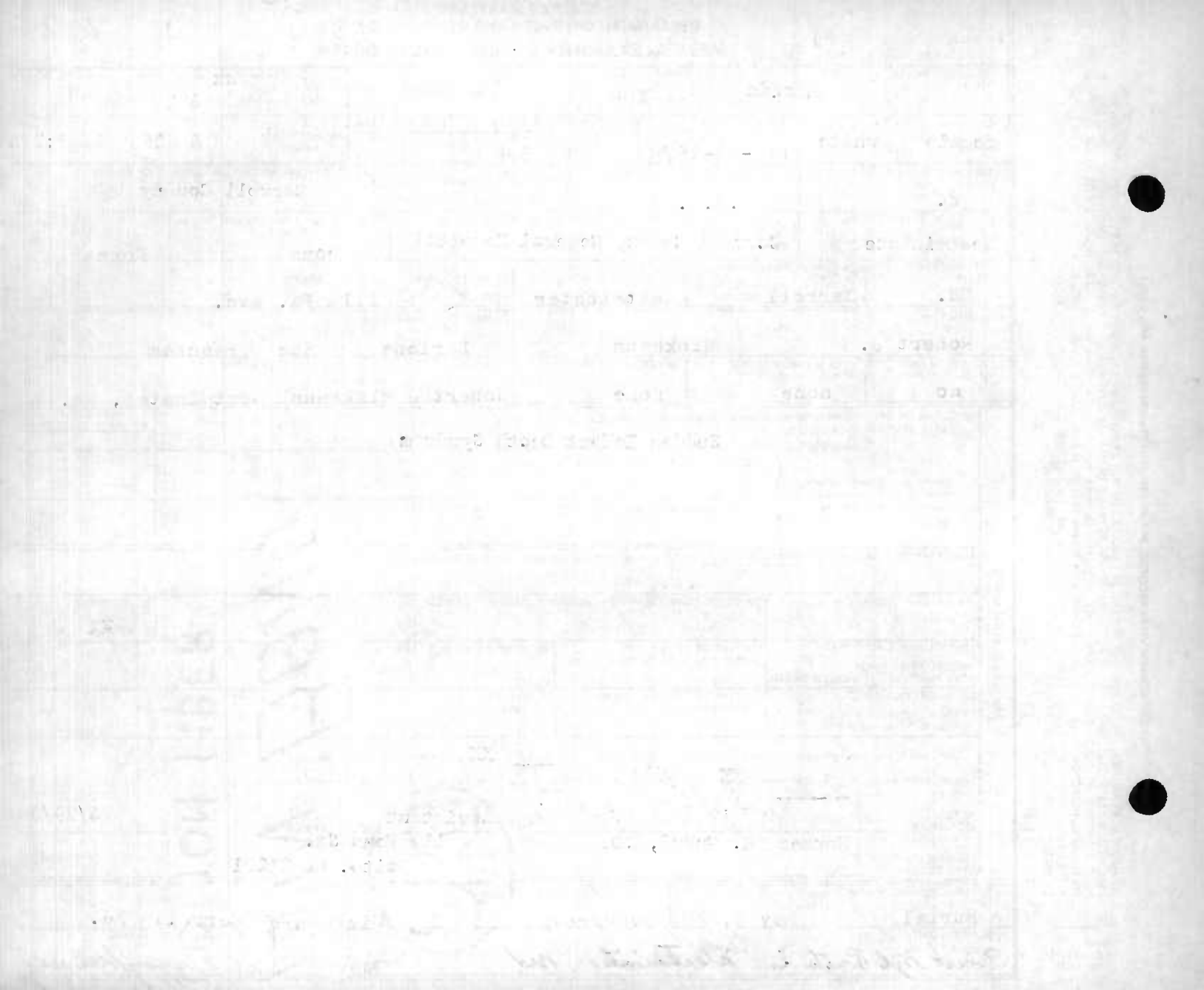
DHM-17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		EST. MONTH DAY YEAR		M	
Amanda Lynn Hinkhaus		4 29 19 80		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
female	white	MONTH DAY YEAR	LAST BIRTHDAY YRS.	MONTHS DAYS	HOURS MIN.
		11 -24-1979	5		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
Md.	U.S.A.	9. BALTIMORE CITY OR COUNTY OF DEATH			
		Carroll County MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Westminster	Carroll County General Hospital		None		None
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.	Carroll	Westminster	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	111 1/2 Pa. Ave.	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		
FIRST MIDDLE LAST	FIRST MIDDLE LAST		16b. SOCIAL SECURITY NO.		
Robert J. Hinkhaus	Darlene Sue Beacham		none		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		none		Robert J Hinkhaus Westminster, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(b) _____					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
<i>H. Guard</i>		Assistant		4/29/80	
EXAMINER'S NAME		ADDRESS			
(TYPE OR PRINT)					
Hormez R. Guard, M.D.		111 Penn St.			
		Balto., MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		May 2, 80		Evergreen	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS					
Robert Kyle Butts, Jr. Westminster, Md		MAY 5 1980		<i>Petry/McBrady</i>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 0 2 7 3			
FOR 1- STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Herman Stanley Jones				2a. DATE OF DEATH MONTH DAY YEAR April 29 1980		2b. HOUR 7:00 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11- 13-1903		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10. CITY OR TOWN OF DEATH Finksburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2911 Cederhurst Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Creamery	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS 2911 Cederhurst Road	
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Finksburg		13d. STREET ADDRESS 2911 Cederhurst Road	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas S. Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Reese			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Mary Helen Jones Finksburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma urinary bladder</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Osteosarcoma - generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1889</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>Years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>April 15</u> , 19 <u>65</u> , to <u>April 29</u> , 19 <u>80</u> , that (I) <u>(saw)</u> last saw the deceased alive on <u>April 10</u> , 19 <u>80</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(saw)</u> (did) <u>(not)</u> view the body after death.							
22b. SIGNATURE <u>O. E. McWilliams</u>				22c. DATE SIGNED 4-29-80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) O. E. McWilliams	
22e. ADDRESS 11904 Kesterton Rd Kesterton Md. 21136				22f. ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22g. ADDRESS 11904 Kesterton Rd Kesterton Md. 21136	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-2-1980		23c. NAME OF CEMETERY OR CREMATORY Evergreen		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll Md.	
24. FUNERAL DIRECTOR NAME <u>Robert E. Pruthi</u> ADDRESS <u>Westminster, Md.</u>				25a. DATE REC'D. BY REGISTRAR <u>MAY 3 1980</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										8010274	
1. DECEASED NAME (TYPE OR PRINT) <i>Raymond Jurgers</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>4-1-80</i>			2b. HOUR <i>12:22 PM</i>			
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 10, 1893</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>87</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Anne Arundel Co.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll Co.</i> MD.					
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll Co. Gen. Hospt.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i> 13b. COUNTY <i>Balto.</i> 13c. CITY OR TOWN <i>Reisterstown</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>420 Westminster Road</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Jurgers</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Georgina Russell</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WW I</i>		17. INFORMANT ADDRESS <i>Mrs. Margaret A. Jurgers Reisterstown, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARDIO-PULMONARY FAILURE</i> <i>185-</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>WIDELY METASTATIC PROSTATIC CA</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF: (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>ASCHD</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>MARCH 27</i> 19 <i>80</i> , to <i>APRIL 1</i> 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>APRIL 1</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>Reynaldo P. Madriana, M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>4/1/80</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>REYNALDO P. MADRIANA</i>				22e. ADDRESS <i>#2 CARROLL PLAZA WESTMINSTER</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>April 5, 80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>		23d. LOCATION CITY OR TOWN STATE <i>Pikesville, Md.</i>					
24. FUNERAL DIRECTOR NAME ADDRESS <i>Eline Funeral Home Reisterstown, Md.</i>											
DATE OF REGISTRATION BY REGISTRAR, REGISTRAR'S SIGNATURE <i>APR 7 1980</i>											



1891	1892	1893	1894	1895	1896	1897	1898	1899	1900	1901	1902	1903	1904	1905	1906	1907	1908	1909	1910	1911	1912	1913	1914	1915	1916	1917	1918	1919	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929	1930	1931	1932	1933	1934	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945	1946	1947	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	2100	2101	2102	2103	2104	2105	2106	2107	2108	2109	2110	2111	2112	2113	2114	2115	2116	2117	2118	2119	2120	2121	2122	2123	2124	2125	2126	2127	2128	2129	2130	2131	2132	2133	2134	2135	2136	2137	2138	2139	2140	2141	2142	2143	2144	2145	2146	2147	2148	2149	2150	2151	2152	2153	2154	2155	2156	2157	2158	2159	2160	2161	2162	2163	2164	2165	2166	2167	2168	2169	2170	2171	2172	2173	2174	2175	2176	2177	2178	2179	2180	2181	2182	2183	2184	2185	2186	2187	2188	2189	2190	2191	2192	2193	2194	2195	2196	2197	2198	2199	2200	2201	2202	2203	2204	2205	2206	2207	2208	2209	2210	2211	2212	2213	2214	2215	2216	2217	2218	2219	2220	2221	2222	2223	2224	2225	2226	2227	2228	2229	2230	2231	2232	2233	2234	2235	2236	2237	2238	2239	2240	2241	2242	2243	2244	2245	2246	2247	2248	2249	2250	2251	2252	2253	2254	2255	2256	2257	2258	2259	2260	2261	2262	2263	2264	2265	2266	2267	2268	2269	2270	2271	2272	2273	2274	2275	2276	2277	2278	2279	2280	2281	2282	2283	2284	2285	2286	2287	2288	2289	2290	2291	2292	2293	2294	2295	2296	2297	2298	2299</
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APR 5 1950

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 0 2 7 5

1. FOR
STATE
REGISTRAR

REG. NO.

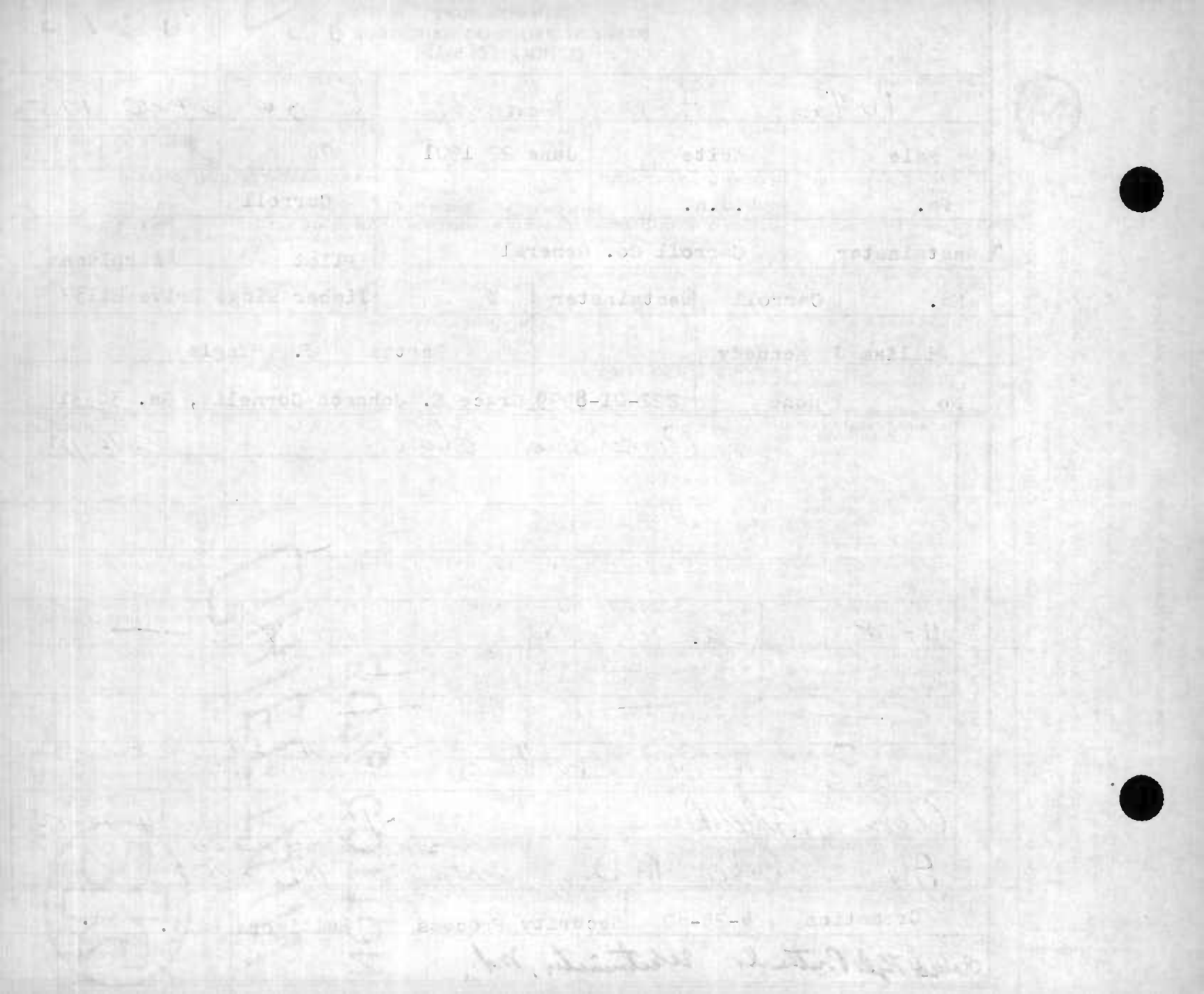
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William A. Kennedy</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>04 24 80</i>		2b. HOUR <i>1715 M</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>June 22 1901</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pa.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> MD.	
10. CITY OR TOWN OF DEATH <i>Westminster</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll Co. General</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Pilot</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Airplanes</i>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <i>Md.</i>	13b. COUNTY <i>Carroll</i>	13c. CITY OR TOWN <i>Westminster</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>Timber Ridge Drive 21157</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William J Kennedy</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bertha J. Engle</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>222-01-8999</i>		17. INFORMANT ADDRESS <i>Grace E. Johnson Cornelia, Ga. 30531</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma, Colon</i> <i>1539</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 yrs</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <i>11-78</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cancer, colon</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <i>11</i> , 19 <i>78</i> , to <i>4-24</i> , 19 <i>80</i> , that (1) (we) last saw the deceased alive on <i>4-24</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Alva S. Baker</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>4-24-80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Alva S. Baker M.D.</i>		22e. ADDRESS <i>218 West 1st St. Md. 21157</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>	23b. DATE <i>4-25-80</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Security Process</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Balt. Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Robert H. Priths Jr.</i>		ADDRESS <i>Westminster, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAY 1 1980</i>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

10276

1. DECEASED-NAME (Type or print) First <i>Helen</i> Middle <i>Lamphear</i> Last <i>Lamphear</i>			2a. DATE OF DEATH <i>April 3</i> Month <i>1980</i> Day Year			2b. HOUR <i>7:30</i> M	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Nov. 9, 1896</i>		6. AGE (In years lost birthday) <i>83</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Indiana</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll County</i> Md.	
10. CITY OR TOWN OF DEATH <i>Eldersburg</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>2204 Sunset Dr.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>---</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Eldersburg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>2204 Sunset Dr.</i>		13f. CITY OR TOWN <i>21784</i>		14. FATHER'S NAME First <i>Harry</i> Middle <i>Yerrick</i> Last <i>Adah</i>		15. MOTHER'S MAIDEN NAME First <i>Unknown</i> Middle <i>Unknown</i> Last <i>Unknown</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16b. SOCIAL SECURITY NO. <i>311-28-4648</i>		17. INFORMANT <i>Annapolis, Md.</i> Address <i>21405</i>		17b. ADDRESS <i>Robert Lamphear 656 Maid Marion Hill</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral anoxia</i> <i>4409</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>---</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>immediatl.</i> <i>yrs.</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		21g. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>10 AM</i> , 19 <i>80</i> , to <i>3 am</i> , 19 <i>80</i> , that (I) (we) saw the deceased alive on <i>3 am</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>W. Choat, M.D.</i>		22c. DATE SIGNED <i>4 apr 80.</i>		22d. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22e. ADDRESS <i>Annapolis, Md.</i>	
22f. PHYSICIAN'S NAME (Type) <i>Dr. William Choat</i>		22g. ADDRESS <i>Annapolis, Md.</i>		22h. ADDRESS <i>Annapolis, Md.</i>		22i. ADDRESS <i>Annapolis, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>April 4, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Westview Memorial Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Catonsville Balto. MD</i>	
24. FUNERAL DIRECTOR <i>8728 Liberty Rd. Randallstown, Md.</i> <i>Loring BYers Funeral Directors, P.A. 21133</i>		25a. REC'D BY REGISTRAR DATE <i>APR 7 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Loring BYers</i>		25c. REGISTRAR'S SIGNATURE <i>Loring BYers</i>	

100-20811-10

100-20811-10

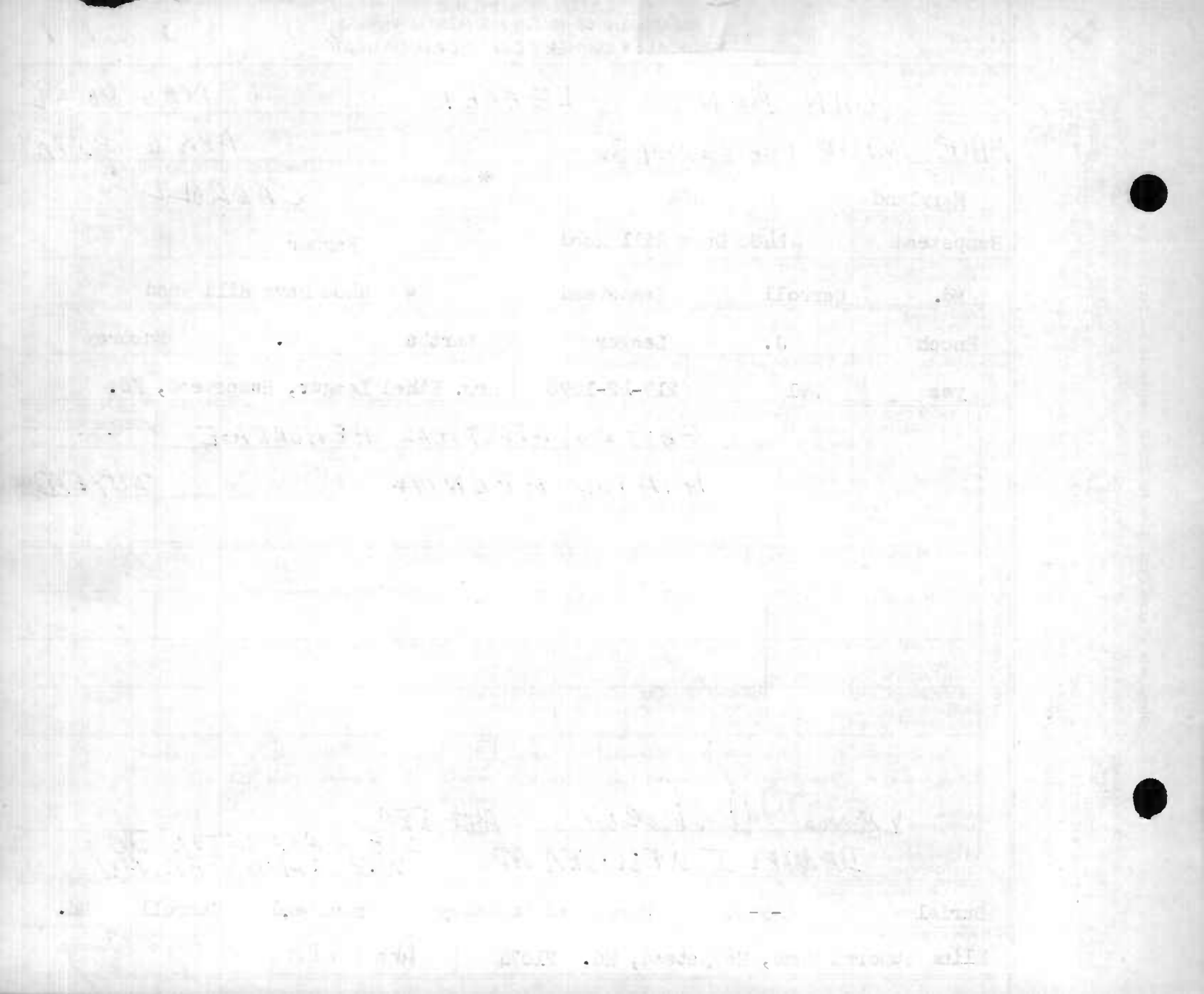
100-20811-10

100-20811-10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (1))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10277	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) JOHN BEN LEAGER						2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR <input type="checkbox"/> MIN APR 6 1980 5 PM			
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH FEB DAY 22 YEAR 1894	6. AGE (IN YEARS) LAST BIRTHDAY 86 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD APR 6 1980		2d. HOUR 7 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.					
10. CITY OR TOWN OF DEATH Hampstead		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4408 Dave Rill Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4408 Dave Rill Road			
14. FATHER'S NAME FIRST Enoch MIDDLE J. LAST Leager		15. MOTHER'S MAIDEN NAME FIRST Martha MIDDLE E. LAST Marbrey		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes							
16b. SOCIAL SECURITY NO. 219-42-1698		17. INFORMANT ADDRESS Mrs. Ethel Leager, Hampstead, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTROINTESTINAL HEMORRAGE 5533 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) HIALUS HERNIA. 20 YEARS (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Daniel J. Welliver		TITLE (SPECIFY) ASST DEP		MEDICAL EXAMINER		DATE SIGNED					
EXAMINER'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER MD		ADDRESS 218 WASHINGTON RD WESTMINSTER MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-9-80		23c. NAME OF CEMETERY OR CREMATORY Hampstead Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Carroll Md.					
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. ADDRESS 21074				25a. DATE REC'D. BY REGISTRAR APR 15 1980		25b. REGISTRAR'S SIGNATURE Patricia McCready					





FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 0 2 7 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Elsie Ann Manthey</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>April 26 1980</i>			2b. HOUR M				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug 23 1923</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>56</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> MD.				
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll Co. General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Factory Worker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>		
13a. STATE <i>Md.</i>			13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Hampstead</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>11 Gill Ave</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Lilburn Van Trent</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Melinda ? Grady</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>				
16b. SOCIAL SECURITY NO. <i>215-22-3089</i>			17. INFORMANT <i>Ronald Chaplain</i>			ADDRESS <i>11 Gill Ave Hampstead, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>OAT CELL CANCER RIGHT LUNG METASTATIC</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>7/3/80</i> , 19____, to <i>4/26/80</i> , 19____, that (I) (we) last saw the deceased alive on <i>4/26/80</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Howard G. Lanham MD</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>4/26/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HOWARD G. LANHAM MD</i>			22e. ADDRESS <i>215 WASHINGTON HETS MED CTN WESTMINSTER</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>4/30/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Lutheran</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Manchester, Cal. Md.</i>		23e. DATE REC'D. BY REGISTRAR	
24. FUNERAL DIRECTOR NAME <i>H. J. Eckhardt</i>			ADDRESS <i>Manchester, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>APR 30 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Barry McCready</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



100-22-101

100-22-101

100-22-101

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M/7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR		8010279	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST <i>Emory L. Martin</i>		MONTH DAY YEAR <i>4 6 1980</i>	
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
Male	White	MONTH DAY YEAR <i>10 28 09</i>	LAST BIRTHDAY <i>70</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Maryland		USA	
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	9. BALTIMORE CITY OR COUNTY OF DEATH	
Westminster	Carroll Co. Gen'l Hospital	Carroll Co.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Operating Eng.		Const.	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Md.	Carroll	Manchester	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST <i>Harry C. Martin</i>		FIRST MIDDLE LAST <i>Sarah J. Hare</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
no		218-07-3449	
17. INFORMANT		ADDRESS	
Mrs. Bernice Martin		Manchester, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atherosclerotic Cardiovascular Disease</i> DUE TO OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Complicated by Hypertension</i> DUE TO OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i> <i>4 yrs</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
<i>[Signature]</i>		M.D. MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
		<i>7 April 80</i>	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE	
Burial		4-9-80	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Evergreen Mem. Gardens		Finksburg Carroll Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
NAME ADDRESS <i>Eline Funeral Home, Hampstead, Md. 21074</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
		APR 15 1980	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Curvin Leroy Michael			2a. DATE OF DEATH Month 4 Day 25 Year 80			2b. HOUR 4:40PM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 2-7-99		6. AGE (In years last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.				
10. CITY OR TOWN OF DEATH Sykesville, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield Hospital Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Md.			13b. COUNTY Balto		13c. CITY OR TOWN Upperco		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 4607 Black Rock Rd.	
14. FATHER'S NAME First J. Middle Edward Last Michael			15. MOTHER'S MAIDEN NAME First Ella Middle Zeigler Last Zeigler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 217-36-4110		17. INFORMANT Address Mrs. Missouri Michael, Upperco, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile process. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH over 10 yrs										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Senile Dementia										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Sep 1st, 1978 to Apr 25th, 1980 , that (I) (we) lost the deceased alive on Apr 25th, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Samuel H. Yoo M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/25/80		
22d. PHYSICIAN'S NAME (Type) Samuel H. Yoo						22e. ADDRESS Springfield Hospital Center				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-28-80		23c. NAME OF CEMETERY OR CREMATORY Grace Cemetery			23d. LOCATION (City or Town) (County) (State) Hampstead Balto Md.		
24. FUNERAL DIRECTOR ADDRESS Eline Funeral Home, Hampstead, Md. 21074						25a. REC'D BY REGISTRAR DATE APR 30 1980		25b. REGISTRAR'S SIGNATURE Hickory McCreedy		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																
1. FOR STATE REGISTRAR					REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR						
FIRST MIDDLE LAST GLADYS M. MILLER					MONTH DAY YEAR April 5, 1980					06 50 A.M.						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.				
FEMALE		WHITE		MONTH DAY YEAR 9 5 02			77 YRS.			MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
BALTIMORE		U.S.A.					CARROLL COUNTY MD.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
WESTMINSTER				CARROLL COUNTY GENERAL HOSPITAL				HOMEMAKER			---					
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
MARYLAND					ANNE ARUNDEL		GLEN BURNIE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 1 Box 290J				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST RICHARD FAULSTICH					FIRST MIDDLE LAST GERTRUDE BARNESLEY											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS									
NO					---		213-12-3231		ANNA JARRETT Rt. 2 Box 38 NEW WINDSOR, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>congestive heart failure</u>																
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic heart disease</u>																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
<u>Cerebrovascular insufficiency</u>																
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>April 3, 1980</u> to <u>April 5, 1980</u> , that (I) (we) last saw the deceased alive on <u>April 5, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>John S. Harsney, MD</u>										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/5/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. HARSNEY, M.D.										22e. ADDRESS 8 Anchor St. Westminster, Md. 21157						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE						
BURIAL					4/8/80		BALTIMORE CEMETERY			BALTIMORE MD.						
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME 4107 WILKENS AVE.										25a. DATE REC'D. BY REGISTRAR APR 7 1980		25b. REGISTRAR'S SIGNATURE <u>Ricky Maloney</u>				



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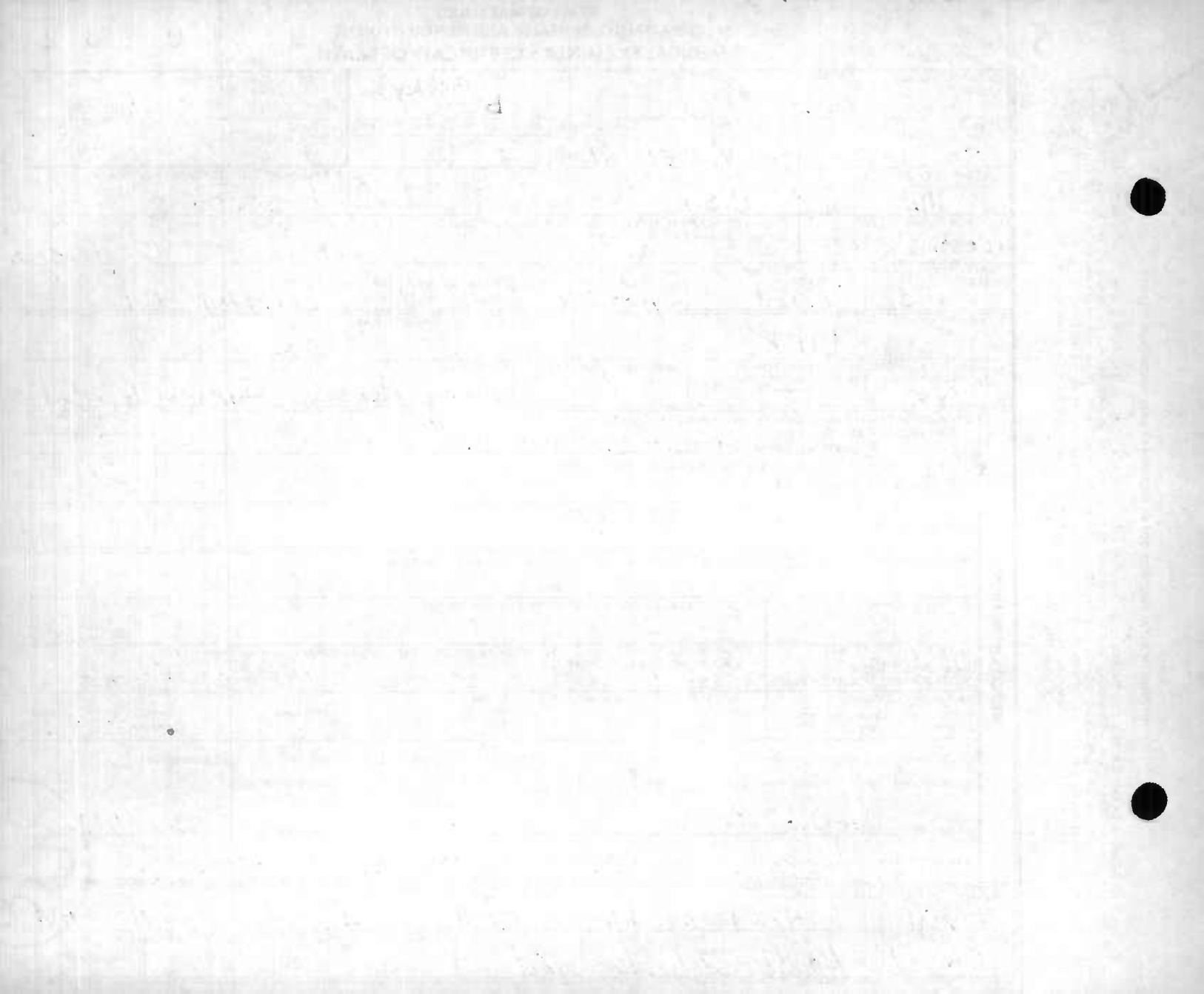
U.S. DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

REG. NO.

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER MUST SIGN AND DATE THE BOTTOM OF THIS CERTIFICATE. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTION CERTIFICATE ARE TO BE FILED IN ITEM "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGES 4 AND 5 ARE TO BE FILED IN ITEM 19. PAGES 6 AND 7 ARE TO BE FILED IN ITEM 20. PAGES 8 AND 9 ARE TO BE FILED IN ITEM 21. PAGES 10 AND 11 ARE TO BE FILED IN ITEM 22. PAGES 12 AND 13 ARE TO BE FILED IN ITEM 23. PAGES 14 AND 15 ARE TO BE FILED IN ITEM 24. PAGES 16 AND 17 ARE TO BE FILED IN ITEM 25. PAGES 18 AND 19 ARE TO BE FILED IN ITEM 26. PAGES 20 AND 21 ARE TO BE FILED IN ITEM 27. PAGES 22 AND 23 ARE TO BE FILED IN ITEM 28. PAGES 24 AND 25 ARE TO BE FILED IN ITEM 29. PAGES 26 AND 27 ARE TO BE FILED IN ITEM 30. PAGES 28 AND 29 ARE TO BE FILED IN ITEM 31. PAGES 30 AND 31 ARE TO BE FILED IN ITEM 32. PAGES 32 AND 33 ARE TO BE FILED IN ITEM 33. PAGES 34 AND 35 ARE TO BE FILED IN ITEM 34. PAGES 36 AND 37 ARE TO BE FILED IN ITEM 35. PAGES 38 AND 39 ARE TO BE FILED IN ITEM 36. PAGES 40 AND 41 ARE TO BE FILED IN ITEM 37. PAGES 42 AND 43 ARE TO BE FILED IN ITEM 38. PAGES 44 AND 45 ARE TO BE FILED IN ITEM 39. PAGES 46 AND 47 ARE TO BE FILED IN ITEM 40. PAGES 48 AND 49 ARE TO BE FILED IN ITEM 41. PAGES 50 AND 51 ARE TO BE FILED IN ITEM 42. PAGES 52 AND 53 ARE TO BE FILED IN ITEM 43. PAGES 54 AND 55 ARE TO BE FILED IN ITEM 44. PAGES 56 AND 57 ARE TO BE FILED IN ITEM 45. PAGES 58 AND 59 ARE TO BE FILED IN ITEM 46. PAGES 60 AND 61 ARE TO BE FILED IN ITEM 47. PAGES 62 AND 63 ARE TO BE FILED IN ITEM 48. PAGES 64 AND 65 ARE TO BE FILED IN ITEM 49. PAGES 66 AND 67 ARE TO BE FILED IN ITEM 50. PAGES 68 AND 69 ARE TO BE FILED IN ITEM 51. PAGES 70 AND 71 ARE TO BE FILED IN ITEM 52. PAGES 72 AND 73 ARE TO BE FILED IN ITEM 53. PAGES 74 AND 75 ARE TO BE FILED IN ITEM 54. PAGES 76 AND 77 ARE TO BE FILED IN ITEM 55. PAGES 78 AND 79 ARE TO BE FILED IN ITEM 56. PAGES 80 AND 81 ARE TO BE FILED IN ITEM 57. PAGES 82 AND 83 ARE TO BE FILED IN ITEM 58. PAGES 84 AND 85 ARE TO BE FILED IN ITEM 59. PAGES 86 AND 87 ARE TO BE FILED IN ITEM 60. PAGES 88 AND 89 ARE TO BE FILED IN ITEM 61. PAGES 90 AND 91 ARE TO BE FILED IN ITEM 62. PAGES 92 AND 93 ARE TO BE FILED IN ITEM 63. PAGES 94 AND 95 ARE TO BE FILED IN ITEM 64. PAGES 96 AND 97 ARE TO BE FILED IN ITEM 65. PAGES 98 AND 99 ARE TO BE FILED IN ITEM 66. PAGES 100 AND 101 ARE TO BE FILED IN ITEM 67. PAGES 102 AND 103 ARE TO BE FILED IN ITEM 68. PAGES 104 AND 105 ARE TO BE FILED IN ITEM 69. PAGES 106 AND 107 ARE TO BE FILED IN ITEM 70. PAGES 108 AND 109 ARE TO BE FILED IN ITEM 71. PAGES 110 AND 111 ARE TO BE FILED IN ITEM 72. PAGES 112 AND 113 ARE TO BE FILED IN ITEM 73. PAGES 114 AND 115 ARE TO BE FILED IN ITEM 74. PAGES 116 AND 117 ARE TO BE FILED IN ITEM 75. PAGES 118 AND 119 ARE TO BE FILED IN ITEM 76. PAGES 120 AND 121 ARE TO BE FILED IN ITEM 77. 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BP _____
DHMH - 17
(VR A15 ME (5))
30M 7/73



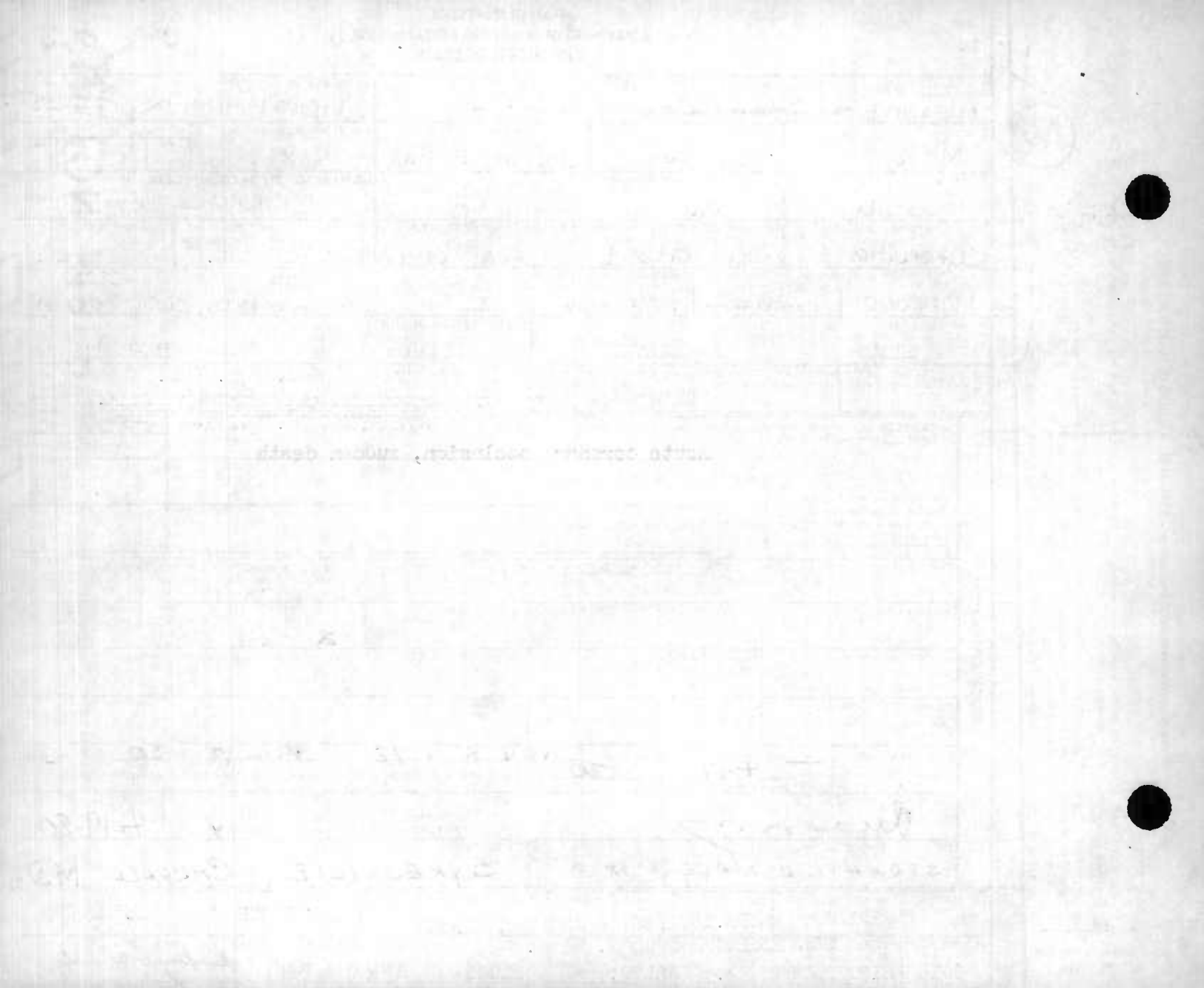
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 0 2 8 3

REG. NO.

1. DECEASED NAME (FIRST, MIDDLE, LAST) Alexander Semionovitch Mostovoy			2a. DATE OF DEATH MONTH DAY YEAR April 17, 1980		2b. HOUR 7:25 P.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 27 1912		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD.	
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANICAL ENG.	12b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Baltimore Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Har Sinai Apts 3601 Fords Lane #21215		
14. FATHER'S NAME FIRST MIDDLE LAST ZEDAL MOSTOVOY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PESAH UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 220-82-9794		17. HEBREW BURIAL & SOC. SER. SOC. Springfield Hebrew Cemetery Sykesville	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion, sudden death 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from NOV. 8, 19 72 , to APRIL 17, 19 80 , that (I) (we) last saw the deceased alive on 4-17, 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature]				22c. DATE SIGNED 4-17-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STRAHIL D. NACEV, M.D.				22e. ADDRESS SYKESVILLE, CARROLL MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE APR. 20, 1980	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		23d. LOCATION BALTIMORE	COUNTY MARYLAND
24. FUNERAL DIRECTOR NAME ADDRESS SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR APR 24 1980	25b. REGISTRAR'S SIGNATURE [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 80 10284			
1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Goldie V. Osborn				4 29 80			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 7 1895		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen'l Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HWR		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. CITY OR TOWN Balto		13c. STREET ADDRESS 15228 Old Hanover Road	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Heintzman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Missouri			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-16-2217		17. INFORMANT ADDRESS Mr. L. Russell Osborn, Upperco, Md.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 410 - DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2]			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/26 19 80 to 4/29 19 80, that (I) (we) lost saw the deceased alive on 4/28 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE (Signature) DEGREE				22c. DATE SIGNED 4/29/80		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-1-80		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Upperco Balto Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home, Hampstead, Md. 21074				25a. DATE REC'D. BY REGISTRAR MAY 5 1980		25b. REGISTRAR'S SIGNATURE (Signature)	

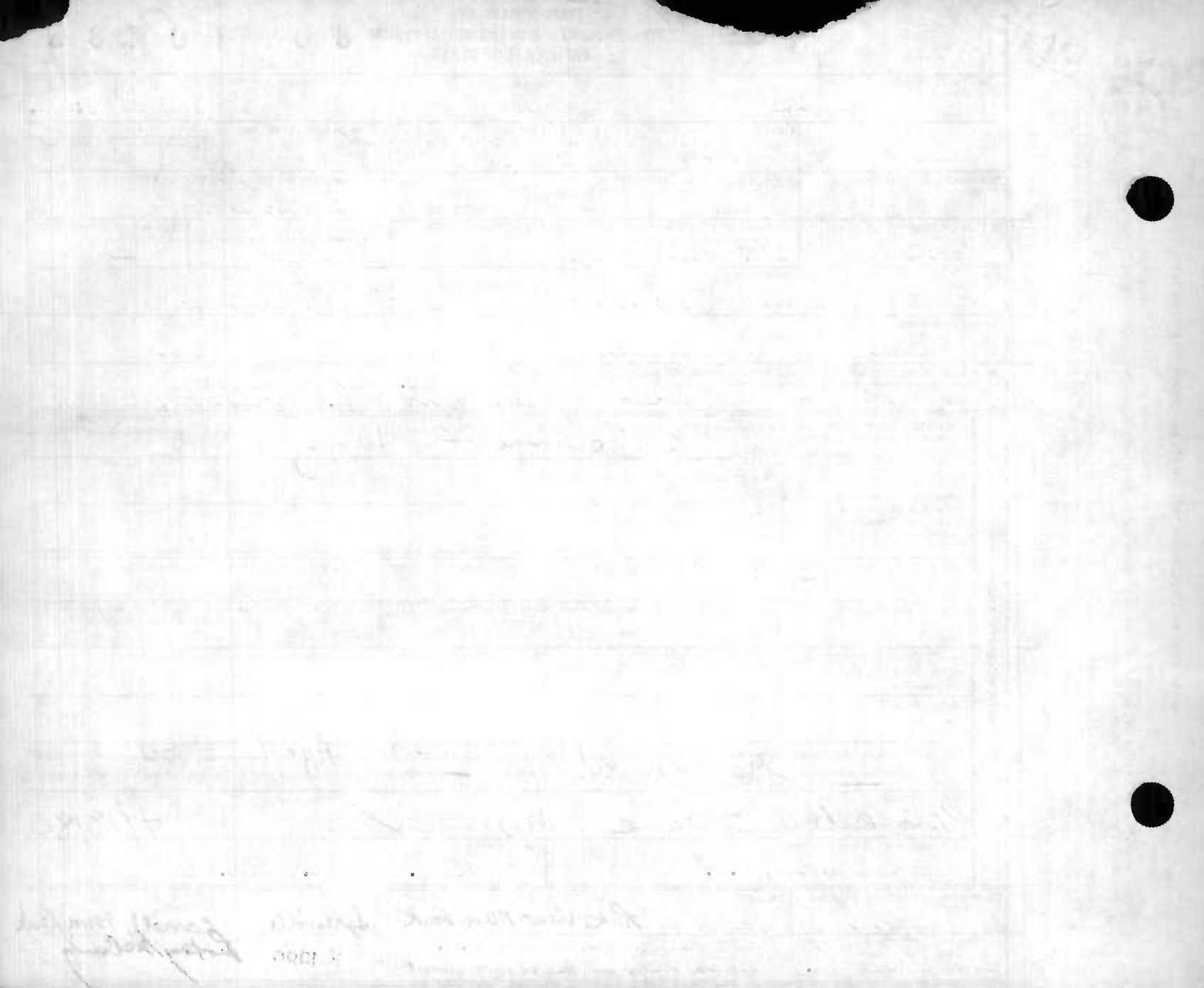
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other funeral.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <i>Regina Petro</i>			2a. DATE OF DEATH MONTH <i>4</i> DAY <i>18</i> YEAR <i>1980</i>		2b. HOUR <i>1:10A</i>					
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH <i>10</i> DAY <i>13</i> YEAR <i>1923</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>56</i> YRS		7. IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>PA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll County</i> MD.				
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1547 Bollinger Road</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>--</i>		
13a. STATE <i>MD</i>			13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Westminster</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>1547 Bollinger Road</i>	
14. FATHER'S NAME FIRST <i>Michael</i> MIDDLE <i></i> LAST <i>Povilaitis</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Magdalen</i> MIDDLE <i>Velyvis</i> LAST <i></i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>096-14-4633</i>		17. INFORMANT ADDRESS <i>Mr. Karl Carmen Petro</i> <i>1547 Bollinger Rd., Westminster, MD 21157</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of lung</i> <i>1639</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>May 19 79</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>May 19 79</i> to <i>April 19 80</i> , that (I) (we) lost saw the deceased alive on <i>March 29, 19 80</i> , and that in (my) <i></i> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <i>Marshall A. Levine</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>4/18/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Marshall Levine, M.D.</i>			22e. ADDRESS <i>711 W. 40th St., Balt. MD</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>4/21/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rose View Mem. Park</i>		23d. LOCATION CITY OR TOWN <i>Lakeville</i> COUNTY <i>Carroll</i> STATE <i>Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Loring Byers Funeral Directors, P.A.</i> ADDRESS <i>8728 Liberty Rd., Randallstown, MD 21133</i>					25a. DATE REC'D. BY REGISTRAR <i>APR 18 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Loring Byers</i>			

BP



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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 0 2 3 6			
1- FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leota M. Phillips							2a. DATE OF DEATH MONTH DAY YEAR April 2, 1980			2b. HOUR 1840 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 28 92			6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.						
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. Gen'l Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hwf		12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							13a. STATE Md.		13b. COUNTY Carroll				
13c. CITY OR TOWN Hampstead		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1369 N. Main St.									
14. FATHER'S NAME FIRST MIDDLE LAST Elisha Snyder				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Mahaley									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-24-5415		17. INFORMANT ADDRESS Mr. Albert A. Phillips, Jr., Hampstead, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from April 2, 1980 to April 2, 1980 , that (I) (we) last saw the deceased alive on April 2, 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE John S. Haskins, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. HASKINS M.D.				22e. ADDRESS 8 Dublin St. Westminster, Md. 21157									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-5-80		23c. NAME OF CEMETERY OR CREMATORY Hampstead Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Carroll Md.						
24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home, Hampstead, Md. 21074						25a. DATE REC'D. BY REGISTRAR APR 10 1980		25b. REGISTRAR'S SIGNATURE John S. Haskins					

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					7 0 1 0 2 8 7	
FOR 1 - STATE REGISTRAR					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Margie L. Pistole			2a. DATE OF DEATH MONTH DAY YEAR 4-2-80		2b. HOUR 0240 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 24 1916		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.		
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. Gen'l Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hwf			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead		
14. FATHER'S NAME FIRST MIDDLE LAST Osborne C. Wilhelm		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Laura Ethel Cofield				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-22-3729		17. INFORMANT ADDRESS Mrs. Claudia Barrett, Reisterstown, Md.		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Left femoral artery occlusion</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> , 19 <u>80</u> , to <u>4/2</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4/2</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>John S. Harsney, M.D.</u>		DEGREE		22c. DATE SIGNED <u>4/2/80</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN S. HARSNEY M.D.</u>		22e. ADDRESS <u>8 Anclum St - Westminster, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-4-80		23c. NAME OF CEMETERY OR CREMATORY Grace Cemetery		
24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home, Hampstead, Md. 21074		23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Balto Md.		25a. DATE REC'D. BY REGISTRAR APR 10 1980		
				25b. REGISTRAR'S SIGNATURE <u>Robert A. [Signature]</u>		

APR 10 1940
Miss Emma J. Jones, Manager, W. J. Smith
Hawthornfield, N.Y.

Dear Miss Jones:
I have just received your letter of the 4th inst. regarding the matter of the purchase of the land for the proposed highway. I am sorry that I cannot give you a more definite answer at this time, but the matter is still under consideration. I will be sure to let you know as soon as a final decision has been reached.

Very truly yours,
John D. Smith

Enclosed for you are two copies of the report of the survey of the proposed highway. I hope this will be of some help to you in your work.

Very truly yours,
John D. Smith

Enclosed for you are two copies of the report of the survey of the proposed highway. I hope this will be of some help to you in your work.

Very truly yours,
John D. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR EDWARD EDWARD					2a. DATE OF DEATH MONTH DAY YEAR April 6, 1980					2b. HOUR P. 8:25 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 25 E. George St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR EQUIPMENT Assembly			
13a. STATE Maryland					13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Paul J. Pittinger					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice - Keeney						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 1 World War II Navy					16b. SOCIAL SECURITY NO. 213-18-9295		17. INFORMANT ADDRESS 25 E. George St. Mrs. JoAnn Deavers, Westminster, Md.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (b) GENERALIZED METASTASIS DUE TO, OR AS A CONSEQUENCE OF (c) MULTIPLE LIVER METASTASIS PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 10-19-79			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 10-19- 19 79 , to 4/6/80 , that (I) (we) lost saw the deceased alive on April 3 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Wenifredo N. Iglesia					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/7/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wenifredo N. Iglesia, M.D.					22e. ADDRESS 49 Frederick St. Taneytown, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/9/1980		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Uniontown, Maryland			
24. FUNERAL DIRECTOR NAME 1004 Harbinger					ADDRESS Union Bridge, Md.			25a. DATE REC'D. BY REGISTRAR APR 9 1980			

750

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Florence Gertrude Powell			2a. DATE OF DEATH 4 Month 15 Day 80 Year			2b. HOUR 5:10 AM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH 7/24/90		6. AGE (In years lost birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County,			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield Hospital Ctr.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Kitchen Worker		12b. KIND OF BUSINESS OR INDUSTRY Food Ind.			
13a. USUAL RESIDENCE (Where deceased lived admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 15414 Holly Grove Road	
14. FATHER'S NAME First Middle Last Charles Powell			15. MOTHER'S MAIDEN NAME First Middle Last Emily Waters						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16b. SOCIAL SECURITY NO. 217-28-8636		17. INFORMANT Address Records, Springfield Hospital Center, Sykesville, Maryland 21784					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 3-21 , 19 72 , to 4-15 , 19 80 , that (I) (we) last saw the deceased alive on 4-15 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Louderes T. Saradpon, M.D.					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNFD 4-15-80		
22d. PHYSICIAN'S NAME (Type) Louderes T. Saradpon, M.D.					22e. ADDRESS Springfield Hospital Center, Sykesville,				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-21-80		23c. NAME OF CEMETERY OR CREMATION Springfield Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville Carroll Md			
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md.					25a. REC'D BY REGISTRAR DATE APR 23 1980		25b. REGISTRAR'S SIGNATURE Walter McCreedy		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF NEW YORK

IN SENATE

January 1, 1901

REPORT OF THE COMMISSIONER OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

APRIL 1, 1900

ALBANY: J.B. LEECH, STATE PRINTER, 1901

1901

1901

ALBANY: J.B. LEECH, STATE PRINTER, 1901

1901

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE. WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A13 ME (5))
15M 7/77

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND

REG. NO.

10290

1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Bent</i>		FIRST <i>F.</i>		MIDDLE <i>Rabbins</i>		LAST <i>Rabbins</i>		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH <i>4</i> DAY <i>3</i> YEAR <i>80</i>		2b. HOUR <i>10:20</i> AM <i>P</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>Jan.</i> DAY <i>18</i> YEAR <i>1907</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS.		IF UNDER 1 YR. MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>		2c. DATE PRONOUNCED DEAD <i>4 3 80</i> MONTH <i>4</i> DAY <i>3</i> YEAR <i>1980</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> MD.					
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll Co. Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farming</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE <i>Pa.</i>		13b. COUNTY <i>York</i>		13c. CITY OR TOWN <i>Greencastle</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>RD #1</i>	
14. FATHER'S NAME FIRST <i>W.</i> MIDDLE <i>M.</i> LAST <i>Rabbins</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Laura</i> MIDDLE <i>Cornett</i> LAST <i>Rabbins</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>577-204466</i>		17. INFORMANT <i>Mrs. Virginia</i>		ADDRESS <i>Rabbins</i>	
18. CAUSE OF DEATH (Enter only one cause of death for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gunshot Wound, Head</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Multiple Fractures of Ribs</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Farm Tractor Accident</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Vermined</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, and an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Richard A. Jones MD</i>		TITLE <i>Deputy</i>		M.D.		MEDICAL EXAMINER		DATE SIGNED <i>3 Apr. 1980</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>Richard A. Jones MD</i>		ADDRESS <i>Carroll County Courthouse Westminister MD</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4/8/80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Salem M.E.</i>		23d. LOCATION CITY OR TOWN <i>Independence</i> COUNTY <i>Wayson</i> STATE <i>Va.</i>					
24. FUNERAL DIRECTOR NAME <i>Joe E. Hoyle</i>		ADDRESS <i>Glenn Rock Pa</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 8 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Hickory, Maryland</i>					

100-100000
100-100000

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First Walter	Middle Leo	Last Russell, Jr.	2a. DATE OF DEATH 04 Month 30 Day 80 Year		2b. HOUR 10:35 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1-27-15		6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS 3 DAYS 3
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County		
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield Hospital Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) odd job		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland		13b. COUNTY City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6408 Clear Spring Road
14. FATHER'S NAME First Walter L. Middle Russell, Sr. Last		15. MOTHER'S MAIDEN NAME First Corrine Middle Whitford Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 218-26-7748		17. INFORMANT Address Records: Springfield Hospital Center				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent carcinoma of the lung 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 08-15 , 19 49 , to 04-30 , 19 80 , that (I) (we) last saw the deceased alive on 04-30 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Dr. Antonius Glahn</i>				22c. DATE SIGNATURE 4-30-80		22d. PHYSICIAN'S NAME (Type) Antonius Glahn, M. D.		
22e. ADDRESS Springfield Hospital Center		22f. ADDRESS Sykesville, MD 21784						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-2-1980		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City or Town) (County) (State) Baltimore Md.		
24. FUNERAL DIRECTOR ADDRESS Charles W. Burrier, Jr., Sykesville, Md.				25a. FILED BY REGISTRAR MAY 5 1980		25b. REGISTRAR'S SIGNATURE <i>Charles W. Burrier, Jr.</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
CENTRAL OFFICE

TO: DIRECTOR, BUREAU OF LAND MANAGEMENT
FROM: SAC, DENVER (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows, appearing to be a memorandum format with various fields and lines of text that are mostly illegible due to the quality of the scan.]

[Illegible text continues, consisting of several paragraphs of text that are mostly illegible due to the quality of the scan. The text appears to be a continuation of the memorandum or a separate document.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 0 1 0 2 9 2						
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		
					JOHN REESE SHIPLEY, SR.					April 12, 1980					19 13 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS						
Male		White		July 31, 1907		72 YRS.		8 MONTHS		11 DAYS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland				U.S.A.								Carroll Co., MD.				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
Westminster				Carroll County General Hospital				Truck Driver								
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Maryland				Carroll		Sykesville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6017 Old Washington Rd.						
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME												
FIRST MIDDLE LAST				FIRST MIDDLE LAST												
Reese (NMN) Shipley				Florence R. Hatfield												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS				
No				218-14-9114				Evelyn H. Shipley, Same As #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recent myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Diabetes Mellitus, systemic Hypertension</u>																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>4-2-</u> 19 <u>80</u> , to <u>4-12-</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4-12-</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE				DEGREE				22c. DATE SIGNED								
<u>Chitrachedu Nagananna</u>				MD				4/12/80								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS												
CHITRACHEDU NAGANNA				174E Main St. - Westminster MD 21157												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial				4-16-1980		Brandenburg				Berrett, Carroll, Md.						
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
						APR 17 1980		<u>Henry McCreary</u>								

BP

Shirley A. Taylor, Jr., Knoxville, Tenn.
4-1-1900
Special Agent in Charge
U. S. Department of Justice
Washington, D. C.

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours truly,
J. Edgar Hoover

Enclosed for you are two copies of a report of the Special Agent in Charge, New York, dated and captioned as above.

Very truly,
J. Edgar Hoover

Special Agent in Charge

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

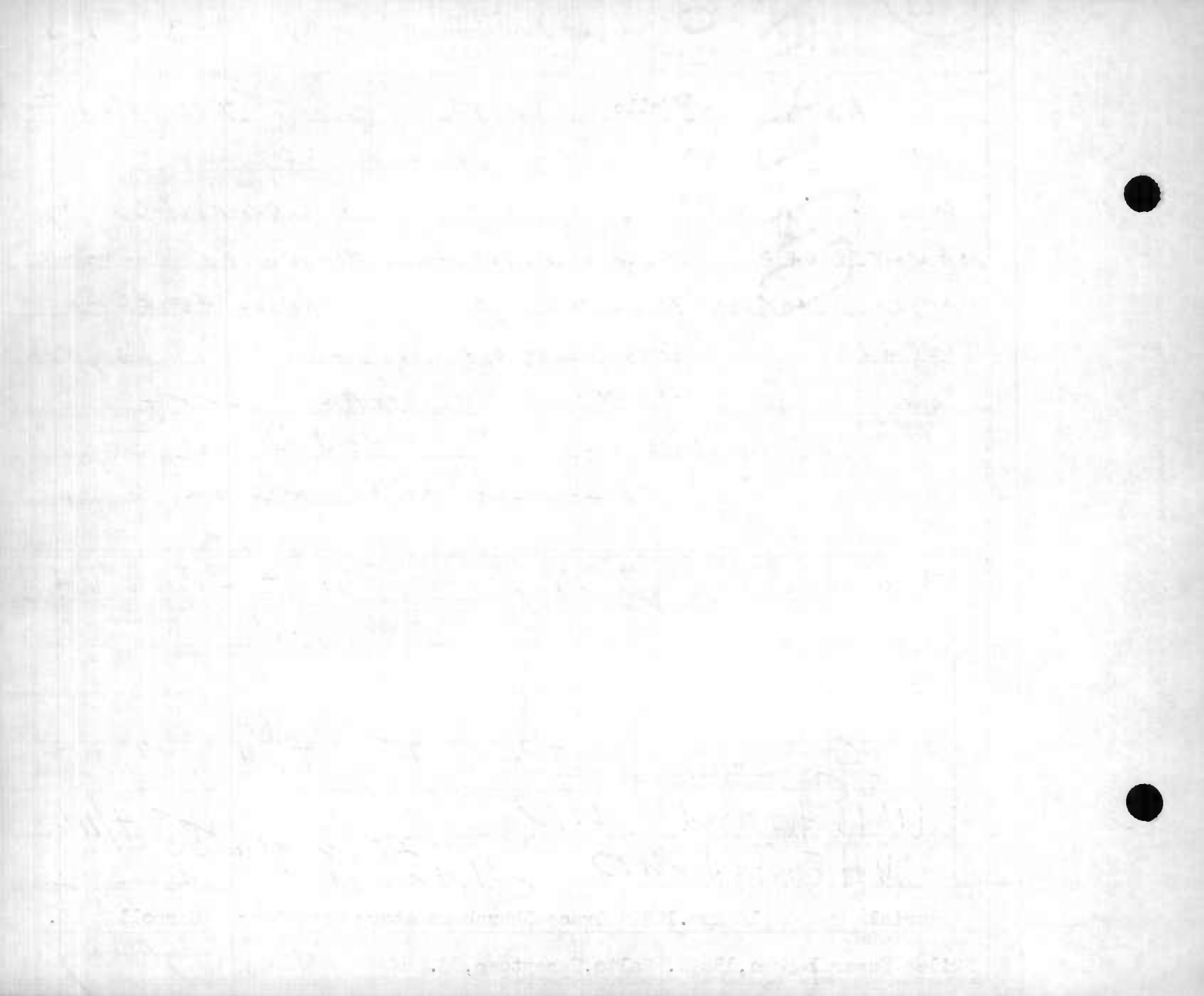
1. DECEASED NAME (TYPE OR PRINT) <i>Natie Belle Smith</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4 11 1980</i>			2b. HOUR <i>11</i> ^A _M			
3. SEX <i>F</i>		4. RACE <i>w</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 24 1893</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>87</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>* Carroll County MD</i>			
10. CITY OR TOWN OF DEATH <i>MANCHESTER</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Long View Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>CARROLL</i>		13c. CITY OR TOWN <i>TANeytown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>CARROLL HEIGHTS</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>RUFUS SPONCELLER</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MANDILLA SNYDER</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>819-01-288</i>		17. INFORMANT <i>J MILLER RN LVAH</i>		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic Heart Disease</i> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <i>generalized arteriosclerotic</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>5 yrs</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c). <i>maxillary lymphadenoma. abscess - Bronchitis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <i>4/12</i> , 19 <i>75</i> , to <i>4/11</i> , 19 <i>80</i> , that (2) we lost saw the deceased alive on <i>4/11</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (2) we did (did not) view the body after death.									
22b. SIGNATURE <i>W H Ford MD</i>				DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>4/11/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W H Ford MD</i>				22e. ADDRESS <i>25 N. Main St Manchester CT, 06112</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>14 Apr. 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Grace Church Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Taneytown Carroll Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Skiles Funeral Home</i>				ADDRESS <i>136 E. Balto. Taneytown, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 16 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Jeffrey McCreedy</i>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Paul Devel Stilts			2a. DATE OF DEATH Month 4 Day 25 Year 80			2b. HOUR 2:45 M					
3. SEX M		4. RACE W		5. DATE OF BIRTH 10-17-48		6. AGE (In years last birthday) 31 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) New York			7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL				
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SALESMAN			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) STATE md			13b. COUNTY WASH.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 936 Hamilton Blvd.		
14. FATHER'S NAME First John Middle R. Last STILTS			15. MOTHER'S MAIDEN NAME First HATTIE Middle DEVEL Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 104-10-4598		17. INFORMANT Address Springfield Hospital Records Sykesville Md 21784						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8-13 19 69 , to 4-25 19 80 , that (I) (we) last saw the deceased alive on 4-25 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Jae M. Park M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED 4-25-80		
22d. PHYSICIAN'S NAME (Type) JAE M. PARK, M.D.						22e. ADDRESS Springfield Hosp. Ctr.					
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 4-28-80		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery Hagerstown			23d. LOCATION (City or Town) (County) (State) Hagerstown Md			
24. FUNERAL DIRECTOR Gerald N. Minnich Hagerstown, Md						25. REGISTRAR'S SIGNATURE [Signature]			DATE APR 30 1980		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS

FILED FOR RECORD

20X DURING THE
20X DURING THE

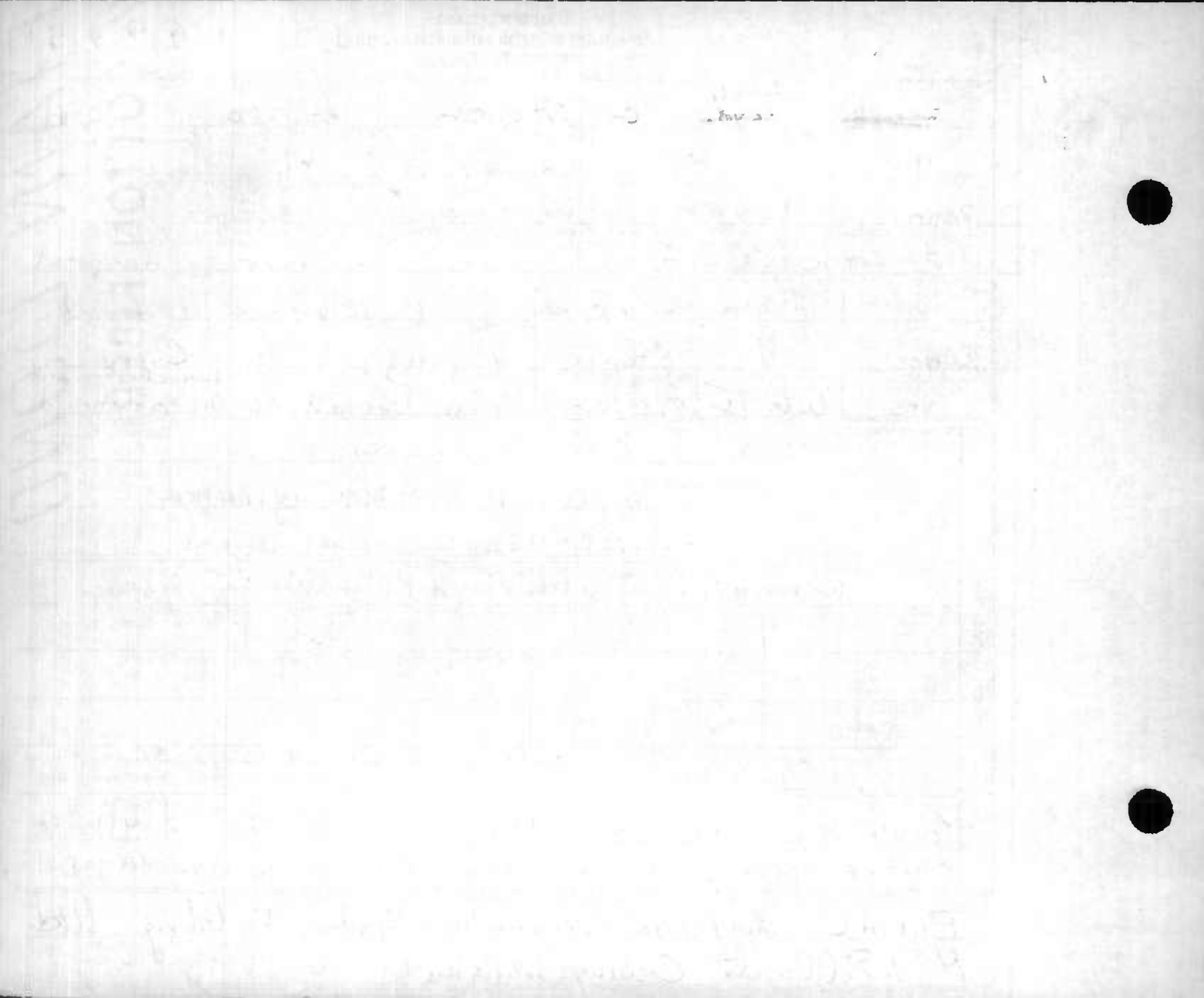
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 0 2 9 5	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Stoner Lloyd G. Stoner				2a. DATE OF DEATH MONTH DAY YEAR 4-15-80				2b. HOUR 0541 M			
3. SEX m.		4. RACE W.		5. DATE OF BIRTH MONTH DAY YEAR 2 26 19		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.					
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) C.C.G. H.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) engineer		12b. KIND OF BUSINESS OR INDUSTRY Hospital			
13a. STATE MD.				13b. COUNTY CARROLL		13c. CITY OR TOWN MANCHESTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3816 MILLERS STATION RD.	
14. FATHER'S NAME FIRST MIDDLE LAST Lloyd M Stoner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Yingling V. Glara							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 166-91-176-0792-63		17. INFORMANT Helen Wennell		ADDRESS Manchester Md 3817 Millers Station Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>TRIPPLE VESSEL CORONARY DISEASE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Rheumatic Heart disease and Multi valvular disease</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-14-</u> 19 <u>80</u> , to <u>4-15-</u> 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>4-14-</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Chitrachedu Nagananna						DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/15/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHEDU NAGANNA						22e. ADDRESS 174 E Main St. Westminster MD 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Apr. 18, 1980		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg Md			
24. FUNERAL DIRECTOR NAME A. J. Ehlhardt						ADDRESS Owings Mills Md		25a. DATE REC'D. BY REGISTRAR APR 22 1980		25b. REGISTRAR'S SIGNATURE Jeffrey McCreedy	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last LORRAINE ADELE TOBERY			2a. DATE OF DEATH Month Day Year April 23 1980			2b. HOUR T:10PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 3, 1919		6. AGE (In years last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Co.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield Hosp Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) house wife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived admission) STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Rosemont Ave.	
14. FATHER'S NAME First Middle Last James C. Kosale			15. MOTHER'S MAIDEN NAME First Middle Last Lucy Ifert						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 215-14-2771A		17. INFORMANT Springfield Hospital		Address Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary arrest 4/5/1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) massive pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 2-26, 1980, to 4-23, 1980, that (I) (we) last saw the deceased alive on 4-23, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Suha Ozgun, M. D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-23-80			
22d. PHYSICIAN'S NAME (Type) Suha Ozgun, M. D.				22e. ADDRESS Springfield Hospital Center Sykesville, MD 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Apr. 26, 1980		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cem.		23d. LOCATION (City or Town) (County) (State) Middletown Fred. Md.			
24. FUNERAL DIRECTOR Gladhill Co. Middletown, Md. 21769				ADDRESS		25a. REC'D BY REGISTRAR DATE APR 29 1980		25b. REGISTRAR'S SIGNATURE Mary McCreedy	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 1 0 2 9 7	
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Daniel Eugene Walsh		April 16, 1980		3:30 a.m.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR
male	XXX cauc.	Dec. 19, 1895	84	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	USA		Carroll MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Westminster	N/A 48 W. Green St.		attorney		LAW
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Carroll	Westminster	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	48 W. Green Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
MICHAEL E. WALSH		ROSE DOYLE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
YES		219-14-9221		MIRIAM WALSH 48 W. GREEN ST. 21157	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Pulmonary edema					
2500 DUE TO, OR AS A CONSEQUENCE OF					
(b) XXXXXXX atherosclerotic cardiovascular disease					
DUE TO, OR AS A CONSEQUENCE OF					
(c) Diabetes mellitus					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the deceased) attended the deceased from Feb. 17, 1965, to present, 1980, that (I) (we) lost the deceased alive on April 14, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		22c. DATE SIGNED		22d. ADDRESS	
Richard Y. Dalrymple, M.D.		4-16-80		Carroll Plaza, Westminster, Md. 21157	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		4-19-1980		ST. JOHNS	
23d. LOCATION		23e. CITY OR TOWN		23f. COUNTY	
WESTMINSTER		CARROLL		MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert Kyle Puth Sr. Westminster, Md.		APR 22 1980		[Signature]	

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0021-9129

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 1 0 2 9 8	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Amey Bell WATKINS				2a. DATE OF DEATH MONTH DAY YEAR April 8 1980				2b. HOUR 7¹⁵ A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 26, 1886		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD.					
10. CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N. Main St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS N. Main St.			
14. FATHER'S NAME FIRST MIDDLE LAST Philip J. Dietrich				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Hyatt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-48-9426		17. INFORMANT ADDRESS E. Church St. Mt. Airy, Md.		17. INFORMANT NAME Delaine Hobbs					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C-V. Disease 4242 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Many years Many years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 67 to April 19 80 , that (I) (we) lost saw the deceased alive on April 7 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE W.B. Culwell MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/9/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William B. Culwell				22e. ADDRESS 4 Culwell Drive - Mt. Airy, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 10, 1980		23c. NAME OF CEMETERY OR CREMATORY Pine Grove		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Airy, Carroll, Md.					
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md.				25a. DATE REC'D. BY REGISTRAR APR 14 1980		25b. REGISTRAR'S SIGNATURE Phyllis McCreedy					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>John Cannon Whitaker</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>4 12 80</i>		2b. HOUR <i>5:15 AM</i>	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>10 6 89</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>90</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		9b. CITIZEN OF WHAT COUNTRY? <i>US</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cornell County</i> MD	
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Westminster Manor & Cornell Care</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SALESMAN</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>Westminster</i>		13c. STREET ADDRESS <i>534 Church Rd -</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Wesley Reed Whitaker</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bertha M. Cannon</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>	
16b. SOCIAL SECURITY NO. <i>220-03-1096</i>		17. INFORMANT <i>Virginia Hilshoff</i>		17b. ADDRESS <i>Laneden Farm Holly, Michigan 48442</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Heart Failure - acute</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Brain Syndrome</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerosis - severe</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>Years</i> <i>Years</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <i>8-1-1953</i> to <i>4-12-1980</i> , that (I) (we) lost saw the deceased alive on <i>4-11-1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>C.E. McWilliams</i>	
22c. DATE SIGNED <i>4-13-80</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>C.E. McWilliams</i>		22e. ADDRESS <i>11904 Kenteston Rd, Kenteston MD 21136</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Apr. 15, 1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenmount Cem</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Maryland</i>		24. FUNERAL DIRECTOR NAME <i>A. E. Ebbhardt</i>		24b. ADDRESS <i>Owings Mills, Md</i>	
25a. DATE REC'D. BY REGISTRAR <i>APR 17 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Mary McHenry</i>		25c. DATE REC'D. BY REGISTRAR <i>APR 17 1980</i>	

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) Hazel Willoughby			2a. DATE OF DEATH Month 04 Day 07 Year 80			2b. HOUR 8:45 MIN A				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 3-27-87		6. AGE (In years last birthday) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll County Md.				
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield Hospital Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) bookkeeper			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY City		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1429 Edmondson Avenue	
14. FATHER'S NAME First Middle Last Arthur B. Willoughby			15. MOTHER'S MAIDEN NAME First Middle Last Catherine Ernst							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No			16b. SOCIAL SECURITY NO. 220-54-6260		17. INFORMANT Address Records, Springfield Hospital Center					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 04-07 , 19 80 to 04-7 , 19 80 , that (I) (we) last saw the deceased alive on 04-07 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Suha Ozgun, M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4-7-80		
22d. PHYSICIAN'S NAME (Type) Suha Ozgun, M.D.						22e. ADDRESS Springfield Hospital Center Sykesville, Maryland 21784				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 4-9-80		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery			23d. LOCATION (City or Town) (County) (State) Rockford Ill.		
24. FUNERAL DIRECTOR Harry W. Haight			ADDRESS Sykesville, Md.			25d. REC'D BY REGISTRAR DATE APR 10 1980		25b. REGISTRAR'S SIGNATURE Robert H. Haight		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem by retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1. STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <i>Helen A. Wisner</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>April 24 1980</i>			2b. HOUR M <i>9 AM</i>	
3. SEX <i>F</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>9 5 1897</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>82</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>CARROLL</i> MD			
10. CITY OR TOWN OF DEATH <i>Manchester</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Long View Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>House wife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>md.</i>		13b. COUNTY <i>CARROLL</i>		13c. CITY OR TOWN <i>Westminster</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>1563 Old Manchester Rd</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Will Harris</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Martha Dell</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>220-01-2874</i>		17. INFORMANT ADDRESS <i>Timonium, md. Louise Wisner - 207 Deep Dale Dr.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> <i>4140</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Cerebral Vascular Insufficiency</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <i>12/22</i> , 19 <i>79</i> , to <i>4/24</i> , 19 <i>80</i> , that (2) I saw the deceased alive on <i>4/20</i> , 19 <i>80</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.									
22b. SIGNATURE <i>W H Foard MD</i>		DEGREE		22c. DATE SIGNED <i>4/24/80</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W H Foard MD</i>		22e. ADDRESS <i>25 N. Main St Manchester MD 21102</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4-26-80</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Trenton Cemetery</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Upperco Balto Md.</i>		
24. FUNERAL DIRECTOR NAME <i>Eline Funeral Home, Hampstead, Md.</i>				ADDRESS <i>21074</i>		25a. DATE REC'D BY REGISTRAR <i>APR 30 1980</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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WATSON, J. R.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	1	0	3	0	2	
FOR 1 - STATE REGISTRAR										REG. NO.							
1 DECEASED NAME (TYPE OR PRINT) Charles Gordon Wratchford										2a. DATE OF DEATH MONTH DAY YEAR April 21, 1980				2b. HOUR P. M. 7:30			
3. SEX Male			4 RACE White			5. DATE OF BIRTH MONTH DAY YEAR March 21, 1905			6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.								
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1666 Liberty Rd.							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mill Operator			12b. KIND OF BUSINESS OR INDUSTRY Crown Cork				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.										13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1666 Liberty Rd.	
14 FATHER'S NAME FIRST MIDDLE LAST George W. Wratchford										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret B. Cook							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 01 0812			17. INFORMANT ADDRESS Edith M. Wratchford Sykesville, Md.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE DUE TO</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C.O.P.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD - CHRONIC BRAIN SYNDROME</u> YRS.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YRS</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>3-2</u> , 19 <u>76</u> , to <u>4-21</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>4-21</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																	
22b. SIGNATURE <u>Naci N. Buyukunsal</u>										DEGREE		22c. DATE SIGNED 4-21-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Naci N. Buyukunsal, M.D.										22e. ADDRESS Sykesville, Maryland 21784							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-23-80			23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Howard, Md.								
24. FUNERAL DIRECTOR NAME Harry W. Haight										ADDRESS Sykesville, Md.		25. DATE REC'D. BY REGISTRAR APR 23 1980		25b. REGISTRAR'S SIGNATURE			

RECEIVED
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C.

MAILED

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 0 1 0 3 0 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Elizabeth Rachel Yates				2a. DATE OF DEATH MONTH 4 DAY 3 YEAR 80		2b. HOUR 4:15P M	
3 SEX Female		4 RACE Negro		5. DATE OF BIRTH MONTH 8 DAY 12 YEAR 13		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10 CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hospital Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST William MIDDLE Chase LAST Chase		15 MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE ? LAST ?		13e. STREET ADDRESS 567 Laurens Street.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-30-5279		17 INFORMANT ADDRESS Mae Mason 1027 Cathedral St. Records, Springfield Hospital Center			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Associated with Vascular							
4148 DUE TO, OR AS A CONSEQUENCE OF Heart Disease							
(b) History of Myocardial Infarction							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
21g. I certify that (X) (this hospital) attended the deceased from 9-24- 19 64 to 4-3- 19 80 , that (X) (we) lost saw the deceased alive on 4-3-80 19 80 , and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.							
21h. SIGNATURE <i>Emmett Madigan M.D.</i> DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/3/80	
22a. PHYSICIAN'S NAME (TYPE OR PRINT) Emmett Madigan M.D.				22b. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/8/80		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION CITY OR TOWN Baltimore COUNTY Baltimore STATE MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR APR 7 1980 25b. REGISTRAR'S SIGNATURE <i>Henry A. ...</i>			

